Simulated Patients: A standardised, quality assured approach to training and implementation

Final Project Report

30th April 2015
Simulated Patients:

A standardised, quality assured approach to training and implementation

www.mmu.ac.uk/simulatedpatient
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Project Team

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*Expertise:* Vast experience of providing accessible, supportive simulation experiences to enhance skills and develop confident, competent healthcare personnel. Particularly interested in using technology, simulation, reflection and debriefing to enhance teaching and learning. Worked closely with Service Users and Carers to integrate their experiences of healthcare into realistic simulated scenarios. Previous research includes working with actors to teach nursing students how to ‘act’ like a nurse.

**Stuart Roberts**

Project Steering Group member & Implementation Team Member  
Senior Lecturer in Adult Nursing, Manchester Metropolitan University (MMU)  
*Expertise:* Previous experience of service users’ involvement in practical exams (OSCEs) for undergraduate (UG) student nurses. Developer of Technology Enhanced Learning strategy for the UG nursing programme at MMU and recently completed a study highlighting the effectiveness of Reusable Learning Objects (RLOs) in teaching UG Student Nurses.
Prof Debra Nestel

Project Consultant & Project Steering Group Member
Professor of Simulation Education in Healthcare for Monash University School of Rural Health.
Expertise: Chair of the NHET Simulation Program. Author of specific NHET modules regarding Standardised Patients. Highly published researcher regarding the role of simulation in supporting learning, particularly in procedural and operative skills. Debra pioneered the concept of patient-focused simulation (PFS) with Prof. Roger Kneebone, which uses a simulated patient and simulator model. Debra has been chief and/or partner investigator in successful grant and tender applications that exceed AU$12m. She has over 120 peer reviewed publications and regularly presents and is invited to deliver keynote presentations at international meetings.

Prof Brian Webster

Project Consultant & Project Steering Group Member
Assistant Dean, Health and Life Sciences, Napier University, Edinburgh
Expertise: Nursing and Health Sciences curricular development, previous Director of Education. Experience of integrating Standardised Patient’s within undergraduate healthcare curricular. Published research in involving service users to give feedback within clinical simulation.
Dr Neil Tuttle

Project Consultant & Project Steering Group Member
Senior Lecturer in Physiotherapy, Griffith University, Brisbane, Australia
Expertise: Received over $1 million off funding for simulated learning projects, including a current project with A/Prof Andrea Bialocerkowski that involves six allied health disciplines. With over 30 years of experience as a clinical physiotherapist, teacher and clinical educator, Dr Tuttle conducts workshops on clinical skills internationally (Australia, the US, Europe, Asia) and is a faculty member of NHET-Sim, a nationally-funded program that trains simulation educators. His primary research areas include evaluation of telemedicine platforms to conduct simulated learning environments and the development and evaluation of spinal palpation simulators.

Mark Hellaby

Project Consultant & Project Steering Group Member
North West Simulation Education Network (NWSEN) Manager
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Consultant in Paediatric Anaesthesia at Royal Manchester Children’s Hospital and a Paediatric Intensive Care Retrieval Physician with the North West & North Wales Paediatric Transfer Service, NWSEN Lead and a Visiting Professor at MMU.

Expertise: currently the Research group chair for the Royal College of Paediatrics & Child Health TEL Committee with collaborative simulation research interests that include: inter-professional in-situ (point of care) simulation; application of debriefing strategies from other industries and validation of simulation assessment and debriefing tools.

Ann Natali

Ann was a lecturer in Adult Nursing for 14 years, prior to retirement in 2013.

Expertise: Her specialist areas are palliative care, acute illness management and clinical skills. Ann has experience of e-learning and clinical simulation with both manikins and simulated patients.

Janet Rooney, Carol Taylor, Rachel Spearing, Stuart Roberts and Janice Murray

MMU Implementation Team

This team of MMU staff consists of Senior Lecturers in Physiotherapy, Nursing and Speech & Language Therapy. They will be responsible for incorporating SPs in their teaching and learning.
Acknowledgements

The Project team would like to acknowledge the Victorian Simulated Patient Network (VSPN), Australia for sharing Simulated Patient learning resources.

The e-learning and workshop material clearly indicates that where VSPN resources, images or videos have been used, they are appropriately acknowledged.

The SP3T course material also indicates that all VSPN video resources are subject to copyright by VSPN (2015) and cannot be downloaded or shared outside of the SP3T course.
Executive Summary

This project has developed, piloted and evaluated a bespoke Simulated Patient Train-The-Trainer (SP3T) programme for Simulation Trainers in the North West of England.

To achieve the overall aim, this project utilised a sequential exploratory mixed methods design, combining quantitative and qualitative data for comprehensive analysis. Firstly, the evidence base was explored to develop a regional questionnaire-based survey and later develop course resources. A regional survey was undertaken with 89 responses gained from 89 participants (working within 24 different organisations including 4 HEIs and 20 NHS Trusts and 31 separate departments). A needs analysis was conducted to establish capacity and demand (see section 3.1).

The overall aim of improving knowledge, awareness and best practice in relation to incorporating SPs within simulation-based education (SBE) or workforce development training programmes in the North West of England, UK has been achieved through a regional survey and four different evaluations of the pilot SP3T programme. The findings from a review of the evidence and survey were used to develop the bespoke standardised, evidence-based SP3T programme. The programme consists of a pre-requisite e-learning course and interactive workshop. Two pilot courses were delivered in February 2015. The evaluation of the e-learning and workshop components is presented in sections 3.3. The final SP3T programme resources include an e-learning course (Virtual Learning Environment (VLE) layout map, 5 e-learning packages, 2 Moodle books, videos and images, e-learning workbook and SP3T e-learning certificate of completion) and SP3T workshop resources (SP role templates, SP feedback templates, workshop course outline, PowerPoint learning and teaching resources, staff briefs including instructions for practical demonstrations and SP3T workshop certificates of participant attendance and Trainer facilitation) (section 3.2.1 and figure 3). All of the resources have been provided to the North West Simulation Education Network (NWSEN) and are currently housed on their (Moodle) VLE. Two additional e-learning Moodle books were developed following the pilot study feedback relating to access issues on NHS computers.

Eighteen SP trainers have now fully completed the SP3T e-learning and workshop programme. Feedback from the 18 participants (from 16 different organisations across the North West of England) and 5 SPs has been incorporated to further develop the SP3T course resources and SP common framework (section 4.1).

The SP common framework (section 4.1) and associated SP3T programme (section 3.2.1) has been designed to empower simulation trainers to effectively work with SPs in education and training, and ultimately lead to improvements in patient safety. The Simulated Patient Common Framework now allows simulation providers and trainers with a reference point from which to guide their work with SPs. This, in turn, should encourage simulation trainers to maximise the potential of embedding SPs in their practice.
1.0 Introduction
There are currently no national guidelines for working with Simulated Patients (SPs) in Simulation Based Education (SBE) in the UK. This study has generated a Train-The-Trainer programme that is applicable to anyone who currently works with or intends to integrate SPs in teaching, learning and assessment across all education and healthcare sectors.

The study findings have been used to develop a common framework, which includes advice, training and guidance for working with and recruitment of SPs. The Train-The-Trainer programme itself, referred to as SP3T, incorporates innovative, flexible methods of delivery, including e-learning and a face-to-face workshop.

This project consisted of a regional survey, literature review and development of evidence-based resources to deliver the SP3T programme.

1.1 Context
Patient volunteers often assist in the delivery of clinical skills as ‘real’ patients. Webster et al. (2012) reported that patient volunteers find this experience rewarding, worthwhile and a way of contributing to the education of student nurses. However, they recognised the need to develop the patient volunteers further (Webster et al., 2012). SPs have potential to be the highest fidelity ‘simulator’ and are well established in most undergraduate medical programs in Australia and Canada (Nestel et al. 2011), but to a lesser extent in the UK.

Simulated Patients are real people trained to portray patients and to give feedback to learners on their interactions. SPs in SBE help to provide a safe environment for the ‘patient’ and learner in which to rehearse ‘patient-centredness’ and other critical aspects of healthcare professionalism (Health Workforce Australia, 2012). Implementation of SPs in SBE also allows students to practice effective communication skills (Francis, 2013) and incorporate the six C’s; Care, Compassion, Competence, Communication, Courage and Commitment (DH, 2012) into their everyday practice.

In the UK, engagement of Service Users as advisors in teaching, research and curriculum development is common in Higher Education Institutions (HEIs) and standardised toolkits for involvement and training and support for peer interviewers are readily available (Working Together Toolkit, nd, INVOLVE, 2012). In addition, the National Service Framework for Mental Health proposes that ‘service users…should be involved in planning, providing and evaluating education and training’ (DH, 1999).
Despite this progress with Service User Involvement in higher education, there is no strategy or guidelines for the involvement of Simulated Patients in HEIs. Additionally, where SPs give feedback to students on their performance, this lacks consistency and can be unpredictable. There is no standardised training programme in the UK or regionally which teaches Simulation Trainers best practice for the involvement of SPs, nor is there a clear training programme available to teach SPs how to deliver constructive feedback to learners in healthcare simulation (Webster et al. 2012).

1.2 Purpose statement and aim
At the time of undertaking this project, the extent to which SPs were involved in SBE in the North West Region of the United Kingdom (UK) was unknown. Additionally, there were no national guidelines for the involvement of SPs in SBE in the UK. The purpose of this project was to develop, pilot and evaluate a bespoke Simulated Patient Train-The-Trainer (SP3T) programme for Simulation Trainers.

The overall aim of this project was to improve knowledge, awareness and best practice in relation to incorporating SPs within SBE or workforce development training programmes in the UK.

1.3 Process
Information on the application of simulated patients to SBE in the North West was gathered using the current evidence base, and by surveying simulation providers. This provided evidence on key elements including; recruitment, payment, expenses, contracts, risk assessment, and terminology. Following this, a needs analysis was performed to establish capacity and demand modelling for the future SP3T programme (NW LETB, 2013). A bespoke programme for the UK based on a best practice model currently used in Australia was then developed. The SP3T programme was piloted in Greater Manchester in partnership with the North West Simulation Education Network (NWSEN). The programme includes e-learning elements and a face-to-face workshop. The common framework has been developed as a result of this project, as presented in figure 1.
2.0 Methodology
To achieve the overall aim, this project utilised a sequential exploratory mixed methods design, combining quantitative and qualitative data for comprehensive analysis (Creswell, 2014). The project has been conducted in two phases:

**Phase 1**
To undertake an in-depth exploration of current practices from Simulation Providers who work with SPs in the North West of England. The findings of the survey conducted in this phase were then used to develop a regional common framework, including advice, and guidance on the involvement of SPs (recruitment, payment and expenses, contracts, risk assessments and training).

**Phase 2**
The information from phase 1 was also utilised to design, develop and pilot a bespoke Simulated Patient ‘Train-The-Trainer’ (SP3T) programme for simulation trainers that will be applicable to anyone who currently works with or intends to integrate SPs into teaching, learning and assessment, across all education and healthcare sectors in the North West of England.

This two-phase approach was considered the most appropriate design for this study as the use of more than one method allowed a more complete picture of the involvement of SPs to be assembled, meet the aims of the study and allow for greater generalisability of the findings (Creswell, 2014).
2.1 Phase 1
A questionnaire-based survey design was used. The questionnaire was designed to establish the extent to which SPs are involved in education and training of undergraduate healthcare students and staff within NHS Trusts across the North West of England (appendix 1). The survey was specifically designed to explore regional practices involving SPs including; terminology, recruitment, payment and expenses, contracts, risk assessment, and training. A self-administered 20-item online questionnaire was designed. This questionnaire featured open and closed questions across 7 sections:

1) Demographics (1 open and 1 mixed response question),
2) SP terminology (1 closed and 1 mixed response question),
3) SP recruitment (1 open and 7 mixed response questions),
4) Payment and expenses for SPs (1 mixed response question),
5) SP contracts (1 closed question),
6) Risk assessment documentation (1 mixed response question),
7) Training (1 open and 4 mixed response questions).

Closed questions featured multiple responses developed to enable ease of completion. Published articles assisted with the development of both closed and multiple response options for questions (Nestel et al, 2011). Multiple response questions featured an ‘other’ option, to facilitate data outside the common categories pre-selected from the literature. Open questions featured text boxes, allowing unlimited text entry. To reduce unnecessary burden of participants’ time, filter questions were utilised. For respondents whose organisation did not currently involve SPs, they were only required to answer questions relating to demographics and the final question regarding future SP related training.

The questionnaire was developed by the authors who had prior experience of working with/recruiting SPs in the UK. Face and content validity of the questionnaire was established by consulting experts in simulation-based education involving SPs and current literature to generate a range of responses to closed questions (Nestel et al, 2011).

Phase 1 regional survey pilot
A pilot of the survey was carried out to assess the accuracy and clarity of the questions. The questionnaire was piloted by 5 members of the SP project team, who had experience of working with/recruiting SPs. Amendments were made in relation to pilot feedback comments including questionnaire content, structure, and layout. The pilot established the questionnaire completion time of up to fifteen minutes (range 8-15 minutes). The questionnaire was designed and piloted to ensure that no harm would arise from participation in the survey.
**Phase 1 regional survey sample**

The sampling frame for phase 1 consisted of all NWSEN network members and healthcare programme/clinical skills/simulation leads on NHS Health Education North West (HENW) commissioned medicine and healthcare programmes, at participating institutions at the time of the study. Thus a range of different organisations involved in education and training of undergraduate healthcare students and staff within NHS Trusts within HENW. The survey population extended to 1 Ambulance Service NHS Trust, 10 Higher Education Institutions (HEIs) and 36 NHS Trusts.

Participants were informed about the regional survey via email which provided a transparent outline of the aims, objectives and procedure. A direct link to the online survey was provided. Full details of the study, aims, intention of publication/presentation of the data generated, respect the participant’s rights for privacy, dignity, confidentiality and anonymity were provided in the opening section of the online survey prior to a question to gain electronic consent. The following question provided an opportunity for participants to provide a unique identification number, (to enable withdrawal of data up until the point of data analysis, which none of the respondents requested to do). Reminder emails were sent after 2 weeks and 4 weeks to increase the response rate. The initial response rate was 73 and rose to 89 following all 3 mailings.

**2.1.1 Phase 1 Data analysis**

The raw data was analysed within Survey Monkey by 2 members of the project team (SG & LG). Descriptive statistical analyses were used to summarise and present quantitative data derived from closed and mixed response questions. Qualitative responses were analysed quantitatively (using content analysis, Creswell, 2014) and qualitatively (by thematic analysis, in accordance with Ritchie and Spencer, 1994). The principal investigators (SG and LG) manually reviewed the qualitative data. Comparisons were made between the qualitative data themes produced by each reviewer and modifications made to create the final themes; aiming to reduce reviewer bias, and provide a reliable and valid analysis (Boyatzis, 1998).

**2.2 Phase 2**

The purpose of this phase of the project was to design, develop and pilot the bespoke SP3T programme. A formal written evaluation via online survey of the e-learning and face-to-face workshop was conducted. The online questionnaire-based survey is presented in appendix 2.

In addition, pre-course expectations and post-course achievements were gathered from the learners (section 3.3).
Immediately following the SP3T pilot workshops, two focus groups were conducted; one with the learners and one with the simulated patients who assisted in taking on roles and were trained by the learners using the methods introduced via the e-learning and workshop demonstrations. The focus group questions are presented in appendix 3. During the focus groups, participants were encouraged to communicate in order to generate data (Kitzinger, 1995). This qualitative method of data collection was selected to encourage participants to ask questions, exchange anecdotes and comment on each other's experiences and points of view (Kitzinger, 1994), which is a common method used in the debriefing stage of simulation based education and one that the participants of this study were familiar with.

The impact of the participants' engagement with the SP3T programme has been analysed via an online impact survey one month post-course (appendix 4).

2.2.1 Phase 2 Data analysis
The raw survey data from all 3 (e-learning, workshop and post-course implementation) questionnaire-based online surveys was analysed within Survey Monkey by 2 members of the project team (SG & LG). Descriptive statistical analyses were used to summarise and present quantitative data derived from closed and mixed response questions. Qualitative responses were analysed quantitatively using content analysis (Creswell, 2014) and qualitatively by thematic analysis, in accordance with Ritchie and Spencer (1994).

Following the focus groups, data has been drawn together, compared and similar themes discussed and examined by the project team using thematic analysis, in accordance with Ritchie and Spencer (1994). The process of thematic analysis undertaken in phase 1 (section 2.1.1) was also repeated (by SG and LG) for all 3 online surveys in phase 2.

Data from the survey and evaluation has been subject to triangulation to integrate the findings from phases 1 and 2. The purpose was to generate an overall evaluation of the project and therefore improve the quality of the SP3T programme.
3.0 Results
This section presents the results from phases 1 and 2. Phase 1 features a regional survey to explore how SPs are currently involved in learning, teaching and assessment in organisations across North West of England.

Phase 2 results include four different evaluations following the design, development and pilot the bespoke SP3T programme:

1) online surveys relating to the e-learning and workshop components of the SP3T course
2) Pre-course expectations and post-course achievement cards
3) Focus groups
4) Evaluation of the impact of participation in the SP3T course, one-month later (post-course implementation survey)

3.1 Phase 1 Regional survey

Demographics
Responses were obtained from 89 participants working within 24 different organisations including 4 HEIs and 20 NHS Trusts and 31 separate departments. Seventy-six respondents reported working with SPs within their organisation. Eighty four percent (64/76) currently work with/involve SPS within their organisation, whereas 16% (12/76) did not.

Terminology
For the purpose of this survey, the term SPs were defined as real people trained to portray patients and to give feedback to learners on their interactions. SPs are involved in simulation-based education help to provide a safe environment for the ‘patient’ and learner. Respondents indicated a wide range of terminology is used instead of ‘simulated patient’ (see table 1). Alternative terms included: manikins, volunteers, carer, actor and confederate.
## SP Recruitment

**Table 1: SP terminology and recruitment.**

<table>
<thead>
<tr>
<th>Terminology used within organisations to describe simulated patients</th>
<th>Percentage (number of participants/66 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simulated patient</td>
<td>70 (46/66)</td>
</tr>
<tr>
<td>Service User</td>
<td>20 (13/66)</td>
</tr>
<tr>
<td>Electronic or virtual patient (e.g. an avatar in Second Life)</td>
<td>18 (12/66)</td>
</tr>
<tr>
<td>Standardised patient</td>
<td>14 (9/66)</td>
</tr>
<tr>
<td>Embedded participant</td>
<td>7 (5/66)</td>
</tr>
<tr>
<td>Other</td>
<td>13 (9/66)</td>
</tr>
</tbody>
</table>

### Recruitment preferences

<table>
<thead>
<tr>
<th>Recruitment preferences</th>
<th>Percentage (number of participants/48 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal referral (from staff/educators/medical schools)</td>
<td>46 (22/48)</td>
</tr>
<tr>
<td>Referral from specialist actor agencies</td>
<td>40 (19/48)</td>
</tr>
<tr>
<td>‘Service User’ groups</td>
<td>17 (8/48)</td>
</tr>
<tr>
<td>Amateur dramatic group</td>
<td>13 (6/48)</td>
</tr>
<tr>
<td>Advertisement (e.g. organisation’s website)</td>
<td>2 (1/48)</td>
</tr>
<tr>
<td>Other</td>
<td>33 (16/48)</td>
</tr>
</tbody>
</table>

### Recruitment strategies currently employed

<table>
<thead>
<tr>
<th>Recruitment strategies currently employed</th>
<th>Percentage (number of participants/48 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal referral</td>
<td>46 (22/48)</td>
</tr>
<tr>
<td>Application form and telephone interview</td>
<td>17 (8/48)</td>
</tr>
<tr>
<td>Application and face-to-face interview</td>
<td>4 (2/48)</td>
</tr>
<tr>
<td>Application form only</td>
<td>2 (1/48)</td>
</tr>
<tr>
<td>Other</td>
<td>50 (24/48)</td>
</tr>
</tbody>
</table>

### Recruitment challenges

<table>
<thead>
<tr>
<th>Recruitment challenges</th>
<th>Percentage (number of participants/48 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>44 (21/48)</td>
</tr>
<tr>
<td>No</td>
<td>56 (27/48)</td>
</tr>
</tbody>
</table>

### Diversity of SP recruited by North West organisations

<table>
<thead>
<tr>
<th>Diversity of SP recruited by North West organisations</th>
<th>Percentage (number of participants/48 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>92 (44/48)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>21 (10/48)</td>
</tr>
<tr>
<td>Children</td>
<td>19 (9/48)</td>
</tr>
<tr>
<td>Visually impaired</td>
<td>15 (7/48)</td>
</tr>
<tr>
<td>Hearing impaired</td>
<td>13 (6/48)</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>11 (5/48)</td>
</tr>
<tr>
<td>Interpreters</td>
<td>11 (5/48)</td>
</tr>
<tr>
<td>Other</td>
<td>21 (10/48)</td>
</tr>
</tbody>
</table>

The other SP specialities recruited included: obstetrics, newborn infants and parents, and spinal injuries. A participant indicated that despite trying to recruit hearing impaired SPs, they had been unsuccessful.

### Databases existence for SPs

<table>
<thead>
<tr>
<th>Databases existence for SPs</th>
<th>Percentage (number of participants/48 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsure</td>
<td>40 (19/48)</td>
</tr>
<tr>
<td>No</td>
<td>31 (15/48)</td>
</tr>
<tr>
<td>Yes</td>
<td>29 (14/48)</td>
</tr>
</tbody>
</table>
Other recruitment preferences: simulation facilitators, trained trust staff, students, no recruitment required.

Other recruitment strategies: from local HEIs, organised elsewhere (by HEIs), selection criteria, agency recruit SPs, unknown, involve staff only, (not involved in recruitment) and no recruitment (use virtual reality).

Recruitment challenges
Thematic analysis revealed 3 themes including: recruiting SPs, cost implication and ensuring psychological safety.

Recruiting SPs
Depends on what style of teaching they are being used for. Regular contributors are ideal but establishing new people in more complicated teaching takes a lot of co-ordinating time. Following up the practical requirements of individuals e.g. parking etc. also takes time and commitment. (Respondent 16)

Usually recruit patients from service area as less need for them to travel. (Respondent 22)

(Difficulty in) recruiting SPs
The difficulties in recruiting SPs related to:
Challenges in recruitment of demographic specialities (e.g. young or elderly). It is difficult to get SP’s of a (sic.) middle years, most are either students or retired. Difficulty when require a specific ethnic background. Sometimes age and sex causes and issue. (Respondent 29)

Ensuring a range of patients that represents a cross section of the demographic students will encounter, especially difficult to recruit elderly and children. (Respondent 5)

Because we seek service users with chronic respiratory diseases, we often have drop outs due to illness. (Respondent 2)

Cost implication
Cost issues related to not having a budget to pay for SPs and involvement is based on goodwill or on a sessional basis as funds permit:
There would be a cost implication to some recruitment. (Respondent 10)

Costs and financing of involvement. (Respondent 14)
Cost which means that we only use actors for courses that cover charges i.e. when there is sufficient funding or costs are cover by course fees.  
(Respondent 31)

We do not have a budget to pay SPs. All based on goodwill.  
(Respondent 30)

**Ensuring safety**

*Ensuring safety of both physical and psychological especially where mental health is involved.*  
(Respondent 14)

*We work mainly with people who have learning disabilities; we take care to allow a lot of time for the volunteers to get to know us. We agree scenarios between us, taking care not to impose our requirements if volunteers have better ideas. We also have to allow training time to ensure that they understand and are comfortable with the scenarios. We also allow time following each session.*  
(Respondent 8)

**SP database categories**

Participants were asked to list the categories included in their organisation’s SP database. These included:

- Personal data (age, gender, date of birth, contact details and email address, medical conditions and background (medical/non-medical),
- Roles played,
- Suitable roles,
- Personal interests relating to the conditions.

Some participants indicated that the database/records are held by external organisations/departments. Additionally, participants acknowledged that there was no central organisation between other departments within their organisation regarding the provision of SP database(s).

**SP involvement within NW organisations**

Participants provided details of the focus and challenges of involving SPs in learning/teaching/assessment in NW organisations (table 2).
Table 2: SP involvement in NW organisations.

<table>
<thead>
<tr>
<th>Principal focus of involving simulated patients for the education of staff and students</th>
<th>Percentage (number of participants/48 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching (Undergraduates)</td>
<td>67 (32/48)</td>
</tr>
<tr>
<td>Assessment (Undergraduates)</td>
<td>46 (22/48)</td>
</tr>
<tr>
<td>In-house continuing education courses (CPD/local training)</td>
<td>31 (15/48)</td>
</tr>
<tr>
<td>Teaching (Postgraduates)</td>
<td>27 (13/48)</td>
</tr>
<tr>
<td>Teaching/Assessment of physical examination</td>
<td>27 (13/48)</td>
</tr>
<tr>
<td>Short courses</td>
<td>21 (10/48)</td>
</tr>
<tr>
<td>Piloting simulation-based training/short courses</td>
<td>21 (10/48)</td>
</tr>
<tr>
<td>Teaching/Assessment of intimate examinations (e.g. Breast)</td>
<td>15 (7/48)</td>
</tr>
<tr>
<td>Assessment (postgraduates)</td>
<td>13 (6/48)</td>
</tr>
<tr>
<td>Quality assurance</td>
<td>13 (6/48)</td>
</tr>
<tr>
<td>Participation in research projects</td>
<td>7 (3/48)</td>
</tr>
<tr>
<td>Other</td>
<td>15 (7/48)</td>
</tr>
<tr>
<td>Other roles included: interviewing students, programme development/review, open days and mandatory obstetric training</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges associated with maintaining quality assurance for SP involvement within your organisation (number of participants/36 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time pressures</td>
</tr>
<tr>
<td>Payment</td>
</tr>
<tr>
<td>Training</td>
</tr>
<tr>
<td>Setting standards for recruitment</td>
</tr>
<tr>
<td>Feedback process (to the teaching faculty)</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Other: cost (limited budget/variable cost of SPs, volunteers, no set budget, negotiating contracts, limited to one agency) performance consistency, payment, role portrayal inconsistency, staffing levels, training issues, timing (timetabling, availability issues, no time allocated for training or SP feedback to learners), training (effective training takes time, done elsewhere) none/unknown.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SP compensation for their time (number of participants/47 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flat rate (e.g. half day/full day)</td>
</tr>
<tr>
<td>Organisation funds available (e.g. of teaching and assessment purposes)</td>
</tr>
<tr>
<td>Travel expense reimbursed</td>
</tr>
<tr>
<td>Unsure</td>
</tr>
<tr>
<td>Hourly rate paid</td>
</tr>
<tr>
<td>Voluntary – travel reimbursement only</td>
</tr>
<tr>
<td>Vouchers offered</td>
</tr>
<tr>
<td>Voluntary – travel reimbursement only</td>
</tr>
<tr>
<td>Set travel expenses provided</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Other: agency fee, good will, payment details specified, staff timetabled or time in lieu.</td>
</tr>
</tbody>
</table>
Involvement of SPs within NW organisations
Five organising themes emerged relating to specific examples of how SPs are currently involved within organisations in the NW: skills development, academic examinations, specific scenarios, role portrayal, curriculum/organisational development.

Skills development included: consultation, history taking, clinical/examination skills, assessments (in particular respiratory), patient management, non-technical skills:

- History taking stations. History and examination, information giving, clinical skill stations with added complexity i.e. visually impaired or deaf patient.

(Respondent 6)

Academic examinations
SPs are currently involved in student assessments/OSCEs:

- …[anonymised] Objective Clinical Assessment with the guidance of the doctors for certain conditions that are to be assessed. This usually takes place June each year. The people / patients are asked to be themselves when being involved within medical student assessment process. (Respondent 7)

Specific scenarios
Scenarios included: advanced life support, breaking bad news, breast cancer, challenging behaviour, communication (non-technical skills, consent, involvement of an interpreter), deteriorating patient, do not resuscitate, end of life, ethics, flu vaccination, GP, legal, obstetric drills, oncology, organ donation, patient safety, patient transfer respiratory on-call physiotherapy, mental health, pressure sepsis, trauma and ulcer scenarios

Typical GP scenario scenarios previously devised with specific learning objectives undergraduate medical student is the GP with the simulated patient observed by small group and tutor( the group have been working together with the tutor one day per week for 4 weeks by this stage- safe environment)

Pendleton’s rules for feedback- from all the group and facilitated by the tutor ability to “time out” and have discussion/ rewind/ change student. Ability during what you might have done differently to try it again or different student try it. All students actively engaged in the process. Everyone has a turn. Purpose is to enlarge the students’ repertoire of strategies for dealing with different types of patients and situations and as a means of discussing issues in practice such as safety and amorous patients. (Respondent 22)

Used in communication skills training relating to oncology, palliative and end of life care. Actors are used to simulated patients, relatives and health care professionals in role plays. Scenarios are developed during the training
sessions (i.e. not pre written) based on the areas that learners identify as challenging. For example, responding to difficult questions (“Am I dying?”, "How long have I got left?”, "Why me?" etc.) talking about death, discussing DNACPR, dealing with collusion, denial etc. Handling very angry or distressed patients and relatives, challenging colleague’s decisions or behaviour.  

(Respondent 42)

SP roles
Current SP roles included delivering lectures and involved in workshops, discussions with students (relating to their experiences as service users), confederates within a scenario, undertaking roles a patient/relative and voicing the manikin.

Talking to undergraduates about their experiences of health care services.  

(Respondent 20)

Small group communication scenarios Small group work presenting a problem which the students have to work through and agree a solution. Presenting their experiences in the Health service of various departments. Presenting a medical condition in person. As an assessor of a case study group presentation.  

(Respondent 21)

Curriculum/organisational development
SP involvement in curriculum/organisational development related to participation in inductions (staff/student), customer care training, expert patient programme, open days, programme development, developing resources.

Presenting their experience of the profession to potential new recruits at Open Day…Contributing to programme development.  

(Respondent 21)

Payment and expenses for SPs
Five organising themes emerged relating to the specific payment arrangements were provided by some respondents: agency fee, voluntary, payment details specified, staff timetabled or time in lieu.

Agency fee
The actors are paid a flat fee per session, the agency is then paid a fee on top for organisation.  

(Respondent 2)

Agency rates paid for professional actors, vouchers for simulated patients for LOCAS exams and paid cash £30 1/2 day £60 full day for PACES exams.  

(Respondent 16)
Voluntary
It’s all good will at the moment (Respondent 18)

Most SP's used on voluntary basis unless scenario requires complex emotions then actors are paid for at a flat rate of £50 each for an afternoon. (Respondent 19)

Payment
Payment details specified were highly variable and ranged from £10 per hour, £350 plus VAT (£420) for a 1.5 day course:

Reimbursement for lunch up to a maximum of £5 on production of the receipt. (Respondent 11)

Hourly rate at different rate depending on whether teaching input or meeting or planning for teaching. All organised and administered by service user organisation. University staff just have to confirm hours and type of contribution. (Respondent 10)

Typically £10 per hour (Respondent 7)

£350 + VAT for 1½ day short course (Total £420) £200 plus VAT for 1 day (Total £240) £160 plus VAT for ½ day (Total £192) (Respondent 22)

One of the inhibitors of development at present is the lack of a clear mechanism and funding stream for payment. This aspect has to develop and be driven from either Faculty or University level. (Respondent 1)

Staff timetabled
Use staff already timetabled. (Respondent 13)

Time in lieu
We use staff in work time or give time owing. (Respondent 21)

Contracts and risk assessment provision
Details of contracts and risk assessment provision across NW organisations have been presented in table 3.
Table 3: Contracts and risk assessments.

<table>
<thead>
<tr>
<th>Formal contract provision for SPs (number of participants/47 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsure</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk assessment provision for SPs (number of participants/47 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsure</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

Comments: Risks assessments based on individual SPs. Local risk assessments provided. Risks assessments are not formally identified but the recruitment process covers some areas of risk. Some respondents were unaware of risk assessment documentation within their organisation.

SP specific training provisions

Details of SP specific training provisions within NW organisations have been presented in table 4.

Table 4: Specific training provisions.

<table>
<thead>
<tr>
<th>Training provision within NW organisations (number of participants/46 answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General training prior to any involvement</td>
</tr>
<tr>
<td>Unsure</td>
</tr>
<tr>
<td>Specific role training (e.g. session specific)</td>
</tr>
<tr>
<td>Additional sessions provided for session specific requirements (e.g. involvement in assessments)</td>
</tr>
<tr>
<td>Mandatory training programme</td>
</tr>
<tr>
<td>Specific training on ‘how to give feedback to participants’</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Refresher sessions offered</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Comments: Actor workshops run each academic year, specific training provided (standardisation of role, role expectations and feedback, bi-annual updates) and train-the-trainer sessions provided.
### Training methods currently offered to new SPs within NW organisations

*(number of participants/46 answered question)*

<table>
<thead>
<tr>
<th>Method</th>
<th>Participants</th>
<th>(in parenthesis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsure</td>
<td>39</td>
<td>(18/46)</td>
</tr>
<tr>
<td>Face-to-face training</td>
<td>26</td>
<td>(12/46)</td>
</tr>
<tr>
<td>Workshops</td>
<td>20</td>
<td>(9/46)</td>
</tr>
<tr>
<td>None</td>
<td>15</td>
<td>(7/46)</td>
</tr>
<tr>
<td>E-learning</td>
<td>2</td>
<td>(1/46)</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>(7/46)</td>
</tr>
</tbody>
</table>

**Comments:** Agency led training for SPs then attend specific training they are involved in. Session specific training or outline of requirements of participation e.g. lecture format, workshop learning outcomes and required activities. No training is provided, training package offered elsewhere, none provided as staff used are simulation faculty. Verbal requirements are given prior to the session.

### Challenges when developing training for SPs

*(number of participants/46 answered question)*

<table>
<thead>
<tr>
<th>No</th>
<th>52 (24/46)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>47 (22/46)</td>
</tr>
</tbody>
</table>

**Comments:** Appropriate selection issues, capacity issues, cost saving issue means losing SP involvement, no training at present, time pressures, variable quality of volunteers and unknown issues.

### SP training resources perceived on benefit in the future

*(number of participants/46 answered question)*

<table>
<thead>
<tr>
<th>Resource</th>
<th>Participants</th>
<th>(in parenthesis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Writing SP roles</td>
<td>52</td>
<td>(24/46)</td>
</tr>
<tr>
<td>Introduction of SP methodology</td>
<td>50</td>
<td>(23/46)</td>
</tr>
<tr>
<td>SP programme development</td>
<td>47</td>
<td>(22/46)</td>
</tr>
<tr>
<td>Training SPs to give feedback</td>
<td>47</td>
<td>(22/46)</td>
</tr>
<tr>
<td>Training SPs for role portrayal</td>
<td>46</td>
<td>(21/46)</td>
</tr>
<tr>
<td>Debriefing SPs</td>
<td>41</td>
<td>(19/46)</td>
</tr>
<tr>
<td>Audio-visual use to support feedback/debrief</td>
<td>39</td>
<td>(18/46)</td>
</tr>
<tr>
<td>SPs in interprofessional education</td>
<td>37</td>
<td>(19/46)</td>
</tr>
<tr>
<td>Hybrid simulation (blended approach featuring SPs</td>
<td>35</td>
<td>(16/46)</td>
</tr>
<tr>
<td>SPs in nursing, physiotherapy, allied healthcare</td>
<td>35</td>
<td>(16/46)</td>
</tr>
<tr>
<td>None</td>
<td>15</td>
<td>(7/46)</td>
</tr>
<tr>
<td>Moulage</td>
<td>13</td>
<td>(6/46)</td>
</tr>
</tbody>
</table>

**Additional comments provided by participants**

Additional comments provided by participants related to wanting to be kept informed, provision of additional contacts, happy to support future training, SPs are an area for development. One participant was unsure of the term moulage. Costs were raised in relation to the involvement of SPs currently and in the future:
We need to develop this aspect at present and are actively trying to stimulate greater interest from the wider Department and Faculty as we are not a big enough unit to do everything for ourselves.  

(Respondent 2)

Shame that organisations are having to cut back on this excellent learning resource because of costs.  

(Respondent 8)

I think the role of simulated patient can only expand in the future. The cost of providing this service is also going to increase. Cost effectiveness measures will have to become more relevant in the future.  

(Respondent 9)

I do not personally recruit SP but a programme of developing SP roles would be very useful along with developing standards for a good SP.  

(Respondent 15)
3.2 Phase 2
The needs analysis undertaken in phase 1 established demand for the SP3T programme. A bespoke programme for the North West region was developed based on: current evidence, survey findings (phase 1), and best practice from Australia (Nestel et al, 2011). The intention was to create a replicable, standardised approach to SP practise and training for health and social care educators.

The SP3T programme has been developed using a blend of e-learning modules and face-to-face workshop (figure 2). All of these resources summarised in figure 3 have been provided and uploaded onto the NWSEN Virtual Learning Centre (Moodle platform) in accordance with the project plan. All of the teaching resources have been provided in electronic format (Microsoft Word, PowerPoint and Adobe pdf). The learning resources were developed in accordance with UK accessibility requirements (DDA, 1995; SENDA, 2001; Direct Government, 2010; The Equality Act, 2010; TechDIS, 2012a, 2012b; The University of Bath, 2012; Cullen and Roche, 2012). The e-learning course resources were updated (in March-April 2015) following completion of the pilot study. Two additional Moodle books have been developed to address the access issues raised by the e-learning course participants (section 3.3).

The e-learning components is hosted on the NWSEN Virtual Learning Centre. Screenshots have been presented in appendix 5. SP3T workshop delivery images have been presented in appendix 6.

![Figure 2: SP3T programme overview.](image-url)
3.2.1 Final SP3T programme resources

**e-learning course**
- Virtual Learning Environment (VLE) layout map
- 5 e-learning packages, 2 Moodle books
- Digital resources (images and videos)
- e-learning participant workbook
- SP3T e-learning certificate of completion

**SP3T workshop**
- SP role templates
- SP feedback templates
- Workshop course outline
- PowerPoint learning and teaching resources
- Staff briefs including instructions for practical demonstrations
- SP3T workshop certificates of participant attendance and staff facilitation

Figure 3: SP3T programme resources.
3.3 SP3T pilot and evaluation
The SP3T programme was piloted in Greater Manchester at The Centre, Birchwood Park in partnership with the North West Simulation Education Network (NWSEN). 18 participants completed the pre-requisite e-learning course and attended a one-day face-to-face workshop, which were delivered on the 10th February 2015 (n=8) and 16th February 2015 (n=10).

Participants evaluated the e-learning package via an online survey after completion to assess its content, accessibly and usability. The workshops were evaluated using a pre- and post-course qualitative assessment (see tables 1 and 2) and via focus groups. Thematic analysis of focus groups is presented in section 3.3.3. Implementation and impact was measured one month following SP3T course completion using an online survey. Results of the impact survey are included in section 3.3.5.

3.3.1 e-learning evaluation
Ninety five percent (18/19) participants completed the online evaluation of the SP3T e-learning resources. Of the 18 participants that contributed, only 17 answered all the questions. Fourteen participants (88%, 14/18) reported difficulties viewing the online resources. The majority of difficulties reported related accessibility restrictions on NHS facilities. The inability to access the online resources on NHS IT facilities was reported by 44% (8/18) participants, which meant that the course had to be completed at home. Additionally, participants reported that the problems related to their Trust hardware not having the appropriate version of Internet Explorer (IE version 9 required, whilst Trusts are currently limited to version 7). Participants reported being unable to access the learning packages on an iPad but were able to on Apple Mac, PC and laptops. One participant reported that time taken to register to access the resources (via NWSEN Moodle area) on an iPad and laptop was frustrating.

Table 5 presents the respondents opinions of the regarding online navigation and resource content.
Table 5: SP e-learning survey.

<table>
<thead>
<tr>
<th>Navigation</th>
<th>Percentage (no. of participants/no. who answered question)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Difficult</td>
</tr>
<tr>
<td>Ease of opening the individual online learning resources</td>
<td>0 (0/17)</td>
</tr>
<tr>
<td>Ease of navigation between the sections</td>
<td>0 (0/16)</td>
</tr>
<tr>
<td>The colours were easy to read</td>
<td>0 (0/17)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resource content</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online resources content was aimed at the appropriate level</td>
<td>0 (0/17)</td>
<td>6 (1/17)</td>
<td>17 (3/17)</td>
<td>60 (10/17)</td>
<td>17 (3/17)</td>
</tr>
<tr>
<td>The content was appropriate for the participants’ role</td>
<td>0 (0/17)</td>
<td>6 (1/17)</td>
<td>17 (3/17)</td>
<td>60 (10/17)</td>
<td>17 (3/17)</td>
</tr>
<tr>
<td>It was not necessary to record answers for future reference/CPD purposes</td>
<td>0 (0/15)</td>
<td>0 (0/15)</td>
<td>20 (3/15)</td>
<td>67 (10/15)</td>
<td>13 (2/15)</td>
</tr>
<tr>
<td>The ‘stop and think ‘ learning activities were useful’</td>
<td>0 (0/17)</td>
<td>17 (3/17)</td>
<td>24 (4/17)</td>
<td>42 (7/17)</td>
<td>17 (3/17)</td>
</tr>
<tr>
<td>The material was too in-depth</td>
<td>17 (3/17)</td>
<td>60 (10/17)</td>
<td>17 (3/17)</td>
<td>0 (0/17)</td>
<td>6 (1/17)</td>
</tr>
</tbody>
</table>

Participants provided further details in relation to the navigation difficulties experienced, the layout and content of the individual online learning resources.

**Navigation difficulties**

Difficulties were reported relating to the navigation between e-learning sections including: inability to upload the completed workbook, automatic launching of new sections in individual windows. Participants suggested improving the transition between sections instead of closing the window down.

**Layout of individual sections**

Perceptions of the layout were mixed. Layout issues raised by participants related to being unable to view all elements of the slide in their browser, variable text on slides and difficulty with the font and sizing for dyslexia. The differing location of the next and back button was reported by 2 participants. Whereas others reported no issues with the layout. The colours were deemed acceptable.
The content of the online resources
Two themes emerged relating to positive aspects of the resources and suggested improvements.

Positive aspects of the resources:
- The depth of information and content was appropriate,
- The content was deemed appropriate for novice and experienced simulation facilitators, although some reported that those with little experience may have difficulty providing detailed answers to some of the activities,
- The ‘stop and think’ activities were particularly useful.

Suggested improvements:
- Clarification of who the SP3T programme is suitable for
- Developing resources for all healthcare disciplines
- In the learning activities, change closed for open-ended questions
- Incorporation of the workbook and learning resources as one entity
- Formatting consistency
- Increased interactivity
- Further detail on the application of the 4-stage model
- Possibility of having a version for novice and some for the more experienced
- Provision of the workshop timetable in advance

3.3.2 Workshop evaluation (pre and immediately post-course)
All 18 SP3T workshop participants provided their pre and post-course expectations. The 18 participants were from 16 different organisations across the North West of England. Tables 6 and 7 present the participant reflections of their pre and post-course expectations from both pilot workshops (10th and 16th February). It was evident that despite a clear advertisement of the pilot course on the NWSEN website (inviting participants involved in training SPs) and completing the e-learning course; SP trainers had different motivations and perceptions of the training both pre and post-course. Participants’ perceived achievements also differed.

Participants referred to the 4 or 5 step/stage process, which was developed for this project. Following the pilot, it is now referred to as the ‘SP3T 5 stage training model’, (adapted from Nestel, 2008; Nestel, Fleishman and Bearman, 2015) and is presented in appendix 6.
Table 6: SP3T Pilot 10th February 2015 Pre-course expectations and post-course achievements.

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Pre-course expectations</th>
<th>Post-course achievements</th>
</tr>
</thead>
</table>
| 1)                 | • Learn from colleagues.  
                     • Knowledge, ideas to enhance my teaching.  
                     | • A better understanding of SPs.  
                     • The importance of using SPs in simulation and feedback.  |
| 2)                 | • Safe time to think about SBE and how to make this available for large cohorts in HEI.  
                     • One idea to take away with that’s a ‘runner’ – and to be an enthusiast!  
                     | • Good ideas about how to prepare people to be simulated patients – role, context etc.  
                     • Still need to consider how it is scaled up for large cohorts – programme review will be a timely opportunity.  |
| 3)                 | • Learn how best to train people to be simulated patients to help increase fidelity of our simulation.  
                     • To give me structure when writing scenarios regarding the role of the SPs.  
                     | • Learnt about how we could use the template within our service together with putting the 4-stage model into practice.  
                     • Gained more insight into the experience of the SP and how I can facilitate and debrief for the benefit of the student and the SP.  |
| 4)                 | • Plan for a training day for our local group of simulated patients.  
                     • Motivation to improve our store of scenarios.  
                     | • I am clearer about the content and requirements of such a day, although I still need to take responsibility of actually doing it!  
                     • Yes, have increased both the motivation and knowledge of how to improve them.  |
| 5)                 | • To be able to construct a training course for the SPs that we use.  
                     • To standardise our approach to SP use.  
                     | • Learnt framework for writing an SP training course  
                     • Learnt how to write a SP role  |
| 6)                 | • Best practice in order to develop service of simulated patients.  
                     • Look at how to develop scenarios with simulated patients embedded.  
                     | • To consider the SP and the scenario as separate in order to deliver scenarios which value SPs.  
                     • What ‘I will need to do within the organisation/Governance’ in order to develop SPs.  |
| 7)                 | • Greater understanding of the role of SPs within clinical education.  
                     • Maybe some real examples or experiences to act as a catalyst for future SPs.  
                     | • Broader understanding of the role of the SP in clinical education.  
                     • Feel that I’m now in a better position to facilitate scenarios.  |
| 8)                 | • I am a new to simulation – want to understand/ be confident in the simulation process/structure/quality assurance process.  
                     • To go back to my clinical areas and be able to start simulation based scenarios with my staff.  
                     | • Clarity about the SP role and its makeup.  
                     • Guidance/confidence to facilitate simulation process.  
                     • A structure re options for debrief SPs in/out of role, frameworks/tools to discuss with team. Motivation to ensure simulation is embedded into my work base/team.  |
Table 7: SP3T Pilot 16th February 2015 Pre-course expectations and post-course achievements.

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Pre-course expectations</th>
<th>Post-course achievements</th>
</tr>
</thead>
</table>
| 9)                  | • Methods to prepare our simulated patients for specific roles.  
|                     | • Recruitment of simulated patients. | • 4 stage approach.  
|                     | • Maximise the learning opportunities if/when using SP.  
|                     | • If/when we use SP, that I will be able to train the trainer. | • Prior preparation for SP feedback.  
| 10)                 | • Learn what/how to provide training required to people wishing to support simulation.  
|                     | • Understanding how to use simulation appropriately and meaningfully when roles and scenarios are involved. | • 4 stage SP training model.  
|                     | • Maximise the learning opportunities if/when using SP. | • Tools to prepare the SPs.  
| 11)                 | • To have a better understanding of how SPs are and should be prepared for their role.  
|                     | • To better understand the facilitators' perspective when interacting with SPs. | • Learnt how to apply 4/5 step approach to preparing an SP.  
|                     | • A better understanding of a simple structure with which to brief SPs 4(5) step approach is useful. | • The knowledge of the amount of work to be done to become anything close to standardised!  
|                     | • A structure with which to debrief with SPs and the value of in-role vs out of role feedback. Be pragmatic to the situation. | • More ideas for refresher feedback training.  
|                     | • A better appreciation of the model of training and its use in experiential learning.  
|                     | • More familiar with different approaches to simulation training and the use of SPs. | • Separating the role from the scenario.  
| 12)                 | • Ideas for feedback training.  
|                     | • To find out recruitment/training methods off other organisations. | • A standardised approach for writing and SP role.  
| 13)                 | • Skills in training volunteers to be simulated patients.  
|                     | • How to feedback on performance to improve it. | • A standardised approach for SP debriefing.  
|                     | • To be more familiar with different approach to training and working with SPs.  
|                     | • To understand the 'north west' approach to quality assurance of SP training. | • Learning more about how SPs are used  
|                     | • I feel that SP is a weak point in my simulation knowledge, I hope to understand and appreciate this tool better.  
|                     | • To be able to competently utilise this tool within simulation practices of my trust. | • Considering other ways to develop a role/feedback.  
| 14)                 | • Gain an insight into how to work with simulated patients most effectively.  
|                     | • Learn how to write scenarios and roles for an SP. | • Huge improvement of my understanding of the application of the SP role.  
|                     | • To find out what other organisations do in terms of simulation with SPs. | • New perspectives of how to implement in my own practice.  
| 15)                 | • To find out what other organisations do in terms of simulation with SPs.  
|                     | • To find out how feedback is developed and approaches. | • Learning more about how SPs are used  
| 16)                 | • To find out what other organisations do in terms of simulation with SPs.  
|                     | • To find out how feedback is developed and approaches. | • Considering other ways to develop a role/feedback.  
| 17)                 | • To find out what other organisations do in terms of simulation with SPs.  
|                     | • To find out how feedback is developed and approaches. | • Learning more about how SPs are used  
| 18)                 | • To find out what other organisations do in terms of simulation with SPs.  
|                     | • To find out how feedback is developed and approaches. | • Considering other ways to develop a role/feedback.  

35
3.3.3 Focus group evaluation
The purpose of the focus groups was to evaluate the pilot study workshops from SP and workshop participants’ perspectives. Four focus groups were carried out. Separate focus groups were undertaken at the end of each pilot day (10th and 16th February) for SPs and workshop participants (learners). The questions related to content, format and delivery of the workshop (appendix 3).

**Simulated Patient focus groups**
In question 1, SPs were asked to consider whether the SP3T training differed from previous training they had received. Figure 4 illustrates the thematic analysis for SP focus group question 1.

![Figure 4: How the SP3T training differed from previous SP training.](image)

One global theme emerged: How the SP3T training differed from previous SP training
Three organising themes emerged: never had specific SP training before, better than training prior to SP3T, and improvement of pilot 2 from pilot 1.

**Never had specific SP training before:**
One basic theme emerged: No prior formal training:

- *I haven’t ever directly had SP training before, so it was, er, quite a different experience for me...*  
  (SP2)
- *I haven’t really had SP training before, erm, but I found it helpful. I’ve been given a scenario before but wasn’t really trained with it...*  
  (SP4)
**Better than training prior to SP3T:**
Two basic themes emerged: a structured approach and in-depth training.

**A structured approach:**
I think the structured feedback section was very good… I think it was good to put clear, er, guidelines in place as to what was constructive and what would be detrimental.  

(SP5)

**In-depth training:**
For me, it’s more in detail, very more in detail… how in depth the, er, brief is regarding the characters…

(SP1)
The character development has been really in depth.

(SP4)

**Improved training in pilot 2 than pilot 1:**
Two basic themes emerged: clear training delivery and quality of candidates.

**Clear training delivery:**
...candidates seemed clearer about this today...

(SP1)

**Quality of candidates:**
Trainees seemed better today than last time and had the confidence to change things regarding the role/scenario

(SP1)

Trainees seemed to be better today...

(SP3)

During the discussion, all SPs agreed that the trainees from pilot 2 were more used to simulation than those who attended pilot 1.
In question 2, SPs were then asked to discuss the balance between presentation and practical aspects of the SP3T training course. Figure 5 illustrates the thematic analysis for question 2. One global theme emerged: methods of delivery. Three organising themes emerged: balance, dependent factors and preference for practical methods.

**Figure 5: SP perceptions on the SP3T course delivery methods.**

**Balance**

Two basic themes emerged: positive and negative

*Positive:*

*For me, the delivery in general works well, I think you need to, especially at this stage be discussing lots of stuff... it worked well for me*  
(SP3)

*Delivery okay...*  
(SP5)

*Fair balance*  
(SP1)

*Negative:*

*Erm, I perceive it in a way of, erm, there’s more of a, erm, presentation side to it than practical... people are just generally sat round discussing different aspects instead of, and then the practical side is minimal*  
(SP1)

*Erm, I thought it was a little top heavy in terms of PowerPoint, and I think for me, the most effective, erm, section was the demo...*  
(SP4)

**Dependent factors**

Five basic themes emerged: importance of completing the e-learning course, candidates’ skills, poor information transfer, time and learning resources.

*Importance of completing the e-learning course:*

The difference between trainees who had engaged with the online pre-learning materials was evident:

*It was very clear who had and had not done the e-learning*  
(SP2)
Candidates’ skills:
My group were really clued up... (SP1)
My group last week were good... (SP5)

Poor information transfer:
…I think there was, er, in our case, I think there was a sense of not really being sure what you were supposed to do…we weren’t 100% sure, er, we were both not sure what each one was doing.... (SP3)
I was asked about what stage of MS I had and I didn’t know. (SP1)
I didn’t know what Marina was nervous about. (SP2)

Time: SPs may not have time to look at resources. (SP2)

Learning resources:
I think what could be beneficial as well, from your point of view,...you could have, like, a standard list of questions and then the trainer can pick out the ones that are appropriate to theirs...one standardised sheet and then they pick the appropriate questions. (SP1)

Preference for practical methods
Two basic themes emerged: value of demonstrations and learning resources:

Value of demonstrations:
…the demonstration was clear... (SP2)
…and I think for me, the most effective, erm, section was the demo...the feedback stage wasn’t always understood by the learners, perhaps a demo of this would be helpful? (SP4)

Learning resources:
Whilst all of the SPs agreed that they preferred practical methods of teaching and learning, one participant recognised that they were not included in all aspects of the workshop:
…what I would say is, probably, I wasn’t sat in here for half of the PowerPoints so that’s probably why I think it was fine. (SP2)

In addition, SPs suggested other learning methods to support the delivery:
A video may be helpful to reinforce what exactly is expected of everyone. (SP4)
…er, and I think it would’ve helped perhaps, probably, if you’d of had maybe a video of it done as well, er, and certainly people who are being the sim patients should be shown that… (SP3)
SP3T Learner focus groups
Owing to the differences in learner expectations and experiences, the learner focus groups have been analysed independently.

In question 1, Learners who attended the workshops on 10th and 16th February were asked to consider their experience of the SP3T training workshop. Figures 6 and 7 illustrate the thematic analysis for question 1 in the Learner focus groups.

Analysis of the data from 10th February revealed one global theme: experience of the SP3T Workshop. Three organising themes emerged: differences of opinion, suggested improvements and positives (figure 6).

Figure 6: Workshop participants’ perceptions of their experience of the SP3T course (10th February).

Differences of opinion
Three basic themes emerged: learning environment, SPs too experienced and expectations of participants.

Learning environment:
Wouldn’t it have been fun if we’d had a simulated clinical environment to have a little play with when we were working with our SPs...situation makes all the difference and realism makes all the difference, then why not inject a bit of realism into our setting as well (L1)
...trying to set that scene was difficult when we were just sat around a desk, you know, you just didn’t feel like you could act it out as you would have done in a clinical set-up really (L3)
SPs too experienced:
...I felt a bit like I was being lead in places or because they’ve got so much experience and I’ve got so little you’re going a lot with their knowledge which might not necessarily fit in with the model that we’re trying to learn... (L6)

Expectations of participants:
We didn’t actually do that demo...I thought we were going to go to that step, but we didn’t quite get that step (L7)

Suggested improvements
Two basic themes emerged: follow-up forum for sharing ideas and blank templates.

Follow-up forum for sharing ideas:
You want to be able to use the Moodle area actually, to upload some of our own ideas and get feedback from people we’ve sat with today, on, cos you never see the holes in your own do you...so we don’t lose touch with people we’ve started a journey with and that we continue to be a resource for each other (L1)

Blank templates:
I think having the scenarios pre-written was useful but I still would’ve liked some ownership of, like, going the whole course, from, like, working together with somebody to develop one...so you feel as though you’ve completed the whole process from start to finish (L6)

Positives
Two basic themes emerged: SP experience and SP knowledge.

SP experience:
...and in the time we’ve got today I don’t think that would’ve been possible really, so their experience helps you speed it up, cos they think of ideas like you think of ideas (L7)

SP knowledge:
They gave you knowledge, when you weren’t sure, they gave you a bit of background of what they knew from their experiences... (L4)
Analysis of the data from 16th February revealed one global theme: experience of the SP3T Workshop. Three organising themes emerged: differences of opinion, new knowledge acquired and positives (figure 7).

Figure 7: Workshop participants’ perceptions of their experience of the SP3T course (16th February).

Differences of opinion
Three basic themes emerged: group dynamics, SPs too experienced and expectations of participants.

Group dynamics:
I think sometimes, really, you get to the point that, if you’re two leaders, you’re both trying to lead, or, so, unless you know someone’s personality or, if you’d a few minutes to sort of discuss who’s taking what role, so it was quite difficult...

(L7)

SPs too experienced:
...they have been very good, very consistent, and very similar, just an odd time, I think, there’s a little bit of over-acting
I mean, our actress was fantastic...but I did feel as though I couldn’t teach her anything, because she was teaching me, where if I’d had a neutral, you know, like somebody who’d never done it before, I’d have found as though I could apply what I’ve learned today

(L5)

Expectations of participants:
...well I was sat here thinking I’m not sure what I’m supposed to achieve and that’s why we called [the trainer] for help
Yeah, although we got a lot out of the day, we could’ve got more out of the day

(L5) (L7)
...so, and I guess before I came today, I wasn’t really, em, I thought it might encompass different ways of using simulated patients and different teaching approaches, so...it was fine, but, em, I just expected different

New knowledge acquired
Three basic themes emerged: risks to SPs and learners, safeguarding SPs and learners and learning outcome development.

Risks to SPs and learners:
In end of life care be really, really, really careful about who I use, just for their own protection really. You know, you’re asking them to think about what it’s like to die maybe 3 or 4 times in a day, actors know how to look after themselves

Safeguarding SPs and learners:
One thing that came up and I think it ties into the quality assurance, em, is almost that risk assessment, something I’d not really considered before...the rules of engagement really need to be clear with the role players about, you know, when are they at liberty to stop a scenario
We have this in ALS...we have this kill switch...and that could be something, it’s a good point, it could be utilised in simulation

Learning outcome development:
...it also, again, ties into what your learning outcomes are; are you wanting somebody to deal with a severe anxiety...it’s quite complex really
...the learning outcome is surely to do the observations, identify that this person is very anxious, and then relay that information to someone more senior
...what is the thing that you’re trying to teach or facilitate, what skills are you trying to foster during the scenario because that dictates, almost, the levels at which you pitch your scenario

Positives
Two basic themes emerged: SP presence and multi-professional course.

SP presence:
I think I liked the actual fact that, er, it was a real actor [laughs] that you can actually converse with and clarify, you know, different approaches to dealing with different situations; that was really useful
Really enjoyed having a, you know, a simulated patient who you worked with, you know, that was really good
Multi-professional course:

It’s quite multi, er, multi-disciplinary group, yeah, there’s people from private industry there’s people from healthcare, and there’s, it’s good. 

(L6)

In question 2, Learners who attended the workshops on 10th and 16th February were asked to consider the delivery methods utilised in the SP3T workshop. Figures 7 and 8 illustrate the thematic analysis for question 2 in the learner focus groups.

Data analysis from 10th February revealed one global theme: delivery methods. Four organising themes emerged: positives, participant inexperience, course and suggested improvements (figure 8).

![Diagram](image)

Figure 8: Workshop participants’ perceptions of the delivery methods (10th February).

**Positives**

Eight basic themes emerged: safe learning environment, demonstrations, experiential learning, balanced, continuity, products, SP integration and follow-up.

Some quotes to highlight the positive elements are listed below:

- It was a safe place, where it didn’t matter if you got it wrong (L1)
- ...I think doing helped embed, sort of, what we needed to, em, practice with really (L3)
- I like learning by doing, so it was nice to be able to take what had been presented and have a go at it (L1)
- The balance was fine (L4)
- I thought the balance was good... (L1)
And it was good we had the same SP all the time so you could, just, the continuity was there...so that you could learn the whole picture from one person

(L3)

I think it’s give a lot of food for thought, for obviously simulation away from the manikin, knowing what opportunities there are, what you can take back to your own working environment

(L3)

...fun to learn in tandem, you know, for the future...we shouldn’t learn this craft separately from the SP because we can’t do it without them, so they should be equal partners in it and I think that learning together is a very valuable thing

(L1)

...this has been a real eye opening for me today, I’ve really had to think, and take a step back...I enjoyed it, I enjoyed it immensely

(L2)

**Participant inexperience**

Two basic themes emerged: confusion and lack of understanding.

**Confusion:**

I think, I don’t know if I just got the wrong end of the stick actually, but, you know when we did the feedback exercise, I wasn’t too sure, and we had the template, I wasn’t too sure what the task was

(L5)

...I think for me, the confusion lied in, is, are we just briefing our SP in how to give feedback or are we rehearsing with them in how to give feedback

(L6)

**Lack of understanding:**

I think we also had a bit of a problem because actually we’d been given the simulated patient feedback prompt sheet so, it was almost like we’d been given the answer before we were having the discussion...it didn’t quite feel right in our group

(L8)

**Course**

Two basic themes emerged: pacing and timing.

**Pacing:**

Although the blend was really good, I, I’m quite a slow reader and I found it really difficult in the morning to get to grips with the scenario and keep the pace with the workshop...I found it really difficult to keep up

(L6)

**Timing:**

I think given the time we had, it was best keeping to the same scenario

(L4)

I don’t think you’d have the time, with an inexperienced SP I think you’d need a lot more time

(L7)
**Suggested improvements**

Three basic themes emerged: more demonstrations, rotate and prime SPs and SP role template modifications.

**More demonstrations:**

[The trainer] did a demonstration. We could’ve done a repeat of what [the trainer] done with a different scenario and just done a repeat of that (L7)

**Rotate and prime SPs:**

From my point of view, I think it would’ve helped if they’d been briefed a little bit more (L6)

Just keep it wide; I think the variety’s so big, erm, we could see the talents...I think we could use both [experienced and inexperienced SPs] (L7)

**SP role template modifications:**

...yeah, I mean, there was an area, wasn’t there, in the workbooks where you had to write one, it would be like, quite useful if we’d, just like, shared, you know, gone in pairs and then you could discuss which one you’d do, decide which one you’re gonna go with. (L6)

Assumes there’s only one right way to give feedback, and I don’t think there is...I think some positive statements about the nature and the timeliness of it and the purpose of it, erm, and how it, it, what it’s intent is, rather than this is the right way to do it. (L1)
Data analysis from 16th February revealed one global theme: delivery methods. Four organising themes also emerged: positives, participant inexperience, course and suggested improvements (figure 9).

Figure 9: Workshop participants’ perceptions of the delivery methods (16th February).

**Positives**
Ten basic themes emerged: pre-course learning, demonstrations, experiential learning, balanced, continuity, products, SP role template, group interaction, person centred approach and follow-up.

Some quotations to highlight the positives have been included below:

- *I liked the way we did the e-learning up front, got it out of the way, rather than sitting through loads of PowerPoint slides here.* (L3)
- *I particularly enjoyed doing the practical aspects of it.* (L1)
- *It worked well, it was varied.* (L4)
- *I think it’s been really useful to have a tool to use in the future.* (L7)
- *I thought the second template we were given, though, was more user-friendly; I think the first one was sort of belt and braces, and had everything you would need, whereas from a users point of view, the second template, which was a bit more minimalistic, and in a better flow.* (L6)
- *I liked, erm, the fact we could, er, interact with each other and sort of, er, opens my, sort of, knowledge of how it’s utilised in different ways with different groups of people.* (L4)
- *Yeah, I feel all skilled-up, I feel ready to train some patients.* (L3)
- *I think we’ve been given structure to take away, to work on, which I think is really good, erm, cos we’ve not used simulated patients very much...* (L7)
...the one thing I take from this is, when the students finish in June, er, to September, I’m going to bring in some workshops and get them practising, you know, about giving feedback... (L5)

**Participant inexperience**

One basic theme emerged, anxiety.

**Anxiety**

...the learning objectives in, on this sheet, didn’t match the clinician’s tasks...yeah, I just didn’t know whether it was meant to be, it was just a bit confusing really. (L8)

**Course**

Four basic themes emerged: pacing, timing, original role template and problems with e-learning package.

**Pacing:**

I think I would’ve like the lunch before I did that morning activity, I was, sort of, flagging a bit when we got onto the morning activity. (L3)
It really felt to me, it felt as we hadn’t had a coffee break, because the break we did have was said it was going to be a quick comfort break...by the time it got to lunch time I was nearly losing the will to live. (L1)

**Timing:**

I think I’d have liked, erm, a bit of time for the first workshop, you know, once you’d had the demonstration I think I’d liked a bit of time to sit down and talk about how we were gonna do it... (L5)
...so I’d liked a bit more time as well, just so we could’ve decided who’s taking what road. (L7)
I think the first exercise we did, it, it was a bit of a struggle to have time, cos we had three printed sheets, one each to read and one to change, and, sort of, changing a printed sheet is quite hard when you wanted to move sections...(L8)

**Original role template:**

...so I don’t know, maybe just a template with, so that you could agree the key things that you wanted to transfer from that sheet... (L8)
So yeah, a blank sheet to write, with the headings, would be a much better idea (L7)

**Problems with e-learning package:**

I noticed on one of the slides it said SP as teacher...I don’t like the word teacher when we’re talking about feedback and facilitation because, to me, teacher means imparting knowledge and information and that’s actually almost the
opposite of what we want the person to be doing...teacher’s not the right word in that context. (L1)
I don’t know if anyone else had any problems accessing the e-learning...I tried to access it on an iPad and I couldn’t...and on some of the slides the words were cut off at the bottom. (L4)
...that’s the opposite for me; I couldn’t access it from work, but I could on my iPad. (L1)
...there were a couple of spelling mistakes on the e-learning...on a couple of the slides there was a really strong medical focus and if we’re looking at simulation in the wider picture, we can’t just keep focussing on medics alone. (L1)

**Suggested improvements**

Four basic themes emerged: more demonstrations, rotate SPs, pair novice with experienced course participants and longer course duration.

**More demonstrations:**

*I thought the demo was particularly helpful.* (L2)

**Rotate SPs:**

*Maybe not sticking with the same person then, maybe changing the, erm, SPs to the groups, rotating it, but I don’t know how that would work.* (L4)

**Pair novice with experienced course participants:**

...*it would’ve been really nice to get peoples’ level of experience so that when we were all paired up...we are real novices when it comes to, basically, it might’ve been better if we’d been placed, if you’d got two really experienced people together we might have been able to draw from their experiences.* (L5)

*Big groups, maybe not pairs...we’d, erm, potentially established a four and that would’ve worked out quite well cos then you’ve got greater chance of, er, the possibility to put for novices together is quite hard to do probably isn’t it.* (L4)

**Longer course duration:**

...*I think you’ve packed it a tremendous amount today, you know, this could very much have been a two or three day course really.* (L8)

**3.3.4 Focus group summary**

Simulated patients who took part in the SP3T pilot workshops revealed insight into the unique nature of the SP3T course, they also explored their own perceptions of the SP3T course delivery methods.

Learners who participated in the SP3T course workshops examined their own experience of the workshop and the methods utilised for the workshop delivery. Findings will be discussed in detail in section 4.3.
3.3.5 SP3T Post-course implementation evaluation
The SP3T online survey was distributed via Survey Monkey, one-month post-course. A follow-up email reminder was sent to all course participants.

Demographics
Of the 18 SP3T course participants, 14 (78%) completed the SP3T implementation survey. Two participants reported that in some departments SPs were not currently involved in learning/teaching/assessment.

Participants reflected on the amount of developments required in their organisation when involving SPs:

Following attendance at (sic.) training I realised how much work there is to do and initially I am finding out what resource there would be to support doing this properly. (Respondent 12)

Table 8 presents the perceived challenges, anticipated challenges/barriers to implementing changes relating to elements in the common framework, confidence in specific areas following the SP3T course and elements of the SP3T programme that have been used since participation in the SP3T course.
Table 8: Simulated patient terminology and recruitment strategies.

<table>
<thead>
<tr>
<th>Extent of any change in practice since participation in the SP3T course</th>
<th>Percentage (number of participants/number who answered the question)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No change(s) in practice needed</td>
</tr>
<tr>
<td>SP recruitment strategies</td>
<td>46 (6/13)</td>
</tr>
<tr>
<td>SP selection process</td>
<td>46 (6/13)</td>
</tr>
<tr>
<td>Resource considerations</td>
<td>50 (7/14)</td>
</tr>
<tr>
<td>SP training requirements</td>
<td>29 (4/14)</td>
</tr>
<tr>
<td>SP risk assessments</td>
<td>23 (3/13)</td>
</tr>
<tr>
<td>Quality assurance procedures</td>
<td>36 (5/14)</td>
</tr>
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</table>

Anticipated challenges/barriers to implementing changes relating to elements in the common framework (number of participants/number who answered question)

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50 (7/14)</td>
<td>50 (7/14)</td>
</tr>
</tbody>
</table>

Following completion of the SP3T course participants rated the following their abilities (number of participants/13 answered the question)

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>0 (0/13)</td>
<td>0 (0/13)</td>
<td>0 (0/13)</td>
<td>15 (2/13)</td>
<td>77 (10/13)</td>
<td>8 (1/13)</td>
</tr>
<tr>
<td>Embed the SP role into a simulation scenario</td>
<td>0 (0/13)</td>
<td>0 (0/13)</td>
<td>31 (4/13)</td>
<td>62 (8/13)</td>
<td>8 (1/13)</td>
</tr>
<tr>
<td>Train SPs for role portrayal</td>
<td>0 (0/13)</td>
<td>0 (0/13)</td>
<td>23 (3/13)</td>
<td>69 (9/13)</td>
<td>8 (1/13)</td>
</tr>
<tr>
<td>Train SPs to give feedback</td>
<td>0 (0/14)</td>
<td>0 (0/14)</td>
<td>43 (6/14)</td>
<td>50 (7/17)</td>
<td>7 (1/13)</td>
</tr>
</tbody>
</table>
Perceived greater confidence in specific areas following the SP3T course
(number of participants/13)

<table>
<thead>
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<th></th>
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<th>No</th>
<th>Unsure</th>
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<tr>
<td>Develop SP roles</td>
<td>71 (10/14)</td>
<td>21 (3/14)</td>
<td>7 (1/14)</td>
</tr>
<tr>
<td>Train SPs for role portrayal</td>
<td>71 (10/14)</td>
<td>14 (2/14)</td>
<td>14 (2/14)</td>
</tr>
<tr>
<td>Train SPs to give feedback</td>
<td>50 (7/14)</td>
<td>29 (4/14)</td>
<td>21 (3/14)</td>
</tr>
</tbody>
</table>

Elements of the SP3T programme that have used since participation in the SP3T course
Percentage (number of participants/number who answered the question)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not applicable (in my current role)</th>
<th>Planning on using but not had the opportunity to do so yet</th>
</tr>
</thead>
<tbody>
<tr>
<td>SP3T role template</td>
<td>7 (1/14)</td>
<td>29 (4/14)</td>
<td>21 (3/14)</td>
<td>43 (6/14)</td>
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<tr>
<td>5 stage process of SP training (appendix 6)</td>
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<td>46 (6/13)</td>
<td>15 (2/13)</td>
<td>38 (5/13)</td>
</tr>
<tr>
<td>Embedding SP feedback to the learner</td>
<td>8 (1/13)</td>
<td>38 (5/13)</td>
<td>8 (1/13)</td>
<td>46 (6/13)</td>
</tr>
<tr>
<td>Inviting feedback to the learner</td>
<td>7 (1/14)</td>
<td>43 (6/13)</td>
<td>7 (1/14)</td>
<td>43 (6/14)</td>
</tr>
</tbody>
</table>

Challenges
Two organising themes emerged relating to specific challenges when involving SPs in their current practice: resources and quality assurance.

Resources
The resource challenges related to cost barriers, time and capacity.

Resources may be barrier in terms of time and capacity.  
(Respondent 12)

Quality assurance
A respondent reported departmental consideration being necessary in relation to changing quality assurance procedures:

This process is going to be resource dependant on time, staff, plus the need for risk assessment and quality assurance. This is something that should be
completed; it will need to be discussed within the department as how best we can take it forward.  

(Respondent 7)

Respondent’s reflections on confidence and abilities since participating in the SP3T course

Two organising themes emerged relating to the SP3T course having a positive impact on the respondents’ confidence and no impact on confidence.

Positive impact on the respondents’ confidence

Reflections on their confidence following completion of the course were positive:

- For me the day was more of an introduction the many factors and requirements to best utilise SP. Food for thought for future use of SP.  
  (Respondent 7)

- Feel more confident about having a framework to work around. Need to apply the principles before feeling comfortable.  
  (Respondent 10)

- I think that for the 2nd and 4th points above [referring to embedding the SP role into a simulation scenario and training SPs to give feedback respectively], further practice and trying out will be needed before I feel confident to say I know how to.  
  (Respondent 11)

No impact on confidence

Respondents reflected on having the need for further practice to influence their confidence and already being experienced in SP practice prior to the course:

- I have ticked no as I have been doing the above for a number of years and don’t think the course enhanced my confidence in these areas.  
  (Respondent 9)

Impact of participation on practice

Two respondents provided comments relating to the rating of their perceived impact of the SP3T course on their future practice:

- I already used feedback from SPs to the learners as part of debrief prior to the course. I already asked SPs for feedback as part of QA process prior to the course.  
  (Respondent 3)

- Feel this will be more likely in the future [referring to implementation of elements from the training].  
  (Respondent 7)
4.0 Discussion
This section summarises the development of the SP common framework (section 4.1), key findings from the regional survey (section 4.2) and outcomes from the pilot SP3T programme evaluations are presented (sections 4.3 and 4.4). Recommendations are presented in section 4.5 and further dissemination events have been publicised and details are presented in section 4.6. The final section (4.7) discusses the implications arising from this project.

4.1 The SP common framework
The common framework that has been developed from key topics arising in the literature review, the regional survey (section 3.1) and pilot project evaluation (section 3.3). The ‘SP common framework’ consists of five key components. The framework has been designed to support departments and organisations to plan, develop/integrate, deliver and evaluate SP involvement in SBE in healthcare. The SP common framework has also been developed to support the involvement of SPs within healthcare education and research in the North West of England. It is envisaged that the framework will help to support local developments and encourage collaboration through the establishment of a simulated patient community of practice (Lave and Wenger, 1991). Key considerations for each element of the SP common framework are provided.

The SP common framework has been protected by a creative commons license as follows:

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This license only allows download of the SP3T common framework and it to be shared with others as long as they credit the above team. It cannot be changed in any way or used commercially.
Figure 10: The Simulated Patient Common Framework.

1. Establishment of clear and transparent procedures relating to funding, staffing, training and payment

2. Development of a clear and transparent recruitment strategy, indicating clear selection requirements

3. Ensuring Simulated Patients are appropriately trained to participate in learning, teaching, assessment and research roles

4. Ensuring transparent risk assessment procedures are developed to reflect simulation-based education activities

5. Embedding clear quality assurance procedures to continually drive improvements in healthcare education
Element 1: Resource considerations

A review of the literature and regional survey findings highlighted that SP resources is variable in relation to financial funding and the ability and method of reimbursement of SPs for their time.

Funding:
Resources were reportedly available in the region by Trusts/HEIs to a varied extent to support the involvement of SPs in teaching/assessment and specific research projects. Nestel et al (2011) similarly highlighted a variety in international SP funding models, which identified that university funds were available for teaching and assessment as well as project specific funding by government, research bodies or commissioning institutions. In the UK, payment examples included:

- £30 per hour for teaching,
- £25 per hour for academic examinations,
- £75 for Non-role players for physical examination (per session or approximately £150 per day),
- A 3 hour minimum.

The regional survey (section 3.1) identified a variety of current funding models exist, which were reportedly department/faculty specific. The various funding models included:

- Hourly pay/minimum hour allocation (e.g. 2-3 hours, payments ranging from £10 per hour, £192 (including VAT) for a 1 day course to £420 (including VAT) for a 1½ day course)
- Agency fees payable on top of a flat rate for actors
- Variable rates for different activities (teaching versus assessment)
- Staff timetabled
The regional survey (section 3.1) also highlighted inconsistencies in resources available to reimburse SPs across different departments in the same organisation. It is important to recognise the consistency of reimbursing SPs for their time and consideration of reimbursement for attending training sessions. Considerations which may influence the rate of payment for SP involvement may include: highly emotional scenarios, mental illness portrayal, roles for film making/video for teaching and learning/promotional material, physical examinations, teaching/assessment or research purposes, provision of learner feedback, or based on the quality of performance (Tierney et al, 2015). Where SPs are involved on a voluntary basis, considerations may include reimbursement of travel expenses, provision of refreshments and other gestures of appreciation (e.g. thank you cards/emails).

Element 2: Recruitment and selection processes

The following three themes arose from the literature and survey relating to key considerations when considering SP recruitment: including the development of a clear and transparent recruitment strategy, clear selection requirements and maintaining a database.

Recruitment strategies vary widely both in the UK and internationally (Nestel et al, 2011) and within the NW region (Section 3.1). Key areas to consider within a recruitment strategy include the method of recruitment, outlining a formal process,
which may include an application with or without formal/informal interview. Consideration of the SP role demographics: age/gender/ethnicity/abilities is important and can be reflected as categories in a database.

The strategy may include clear identification of the individual programme, curriculum or course requirements, for example, the frequency and repetition when/where SPs are required and approximate duration. This information will help to develop projected financial resource and training requirements.

The regional survey highlighted the absence of SP specific databases to reflect the involvement of SPs within organisations. When developing an SP database, which could be a paper or digital system, consideration of upkeep and management will be required (Nestel et al, 2011; Tierney et al, 2015). Expensive data management software packages are not cost-effective for small-scale SP involvement. Simple spreadsheets offer the ability to store demographic and generic information under simple headings. One drawback is the difficulty in storing photographs within the individual SP profile. Commercially available SP database management packages are available which have the ability to store and link to SP video footage (Tierney et al, 2015).

The database may feature generic headings including:

- Personal demographic details (e.g. name, address, gender, contact details, emergency contact number(s);
- Physical characteristics (e.g. height, weight, scars, piercings, tattoos);
- Language proficiency (spoken and written);
- Relevant medical history (current and past medical history of relevancy to work as an SP);
- Relevant experience (e.g. acting/role play/SP/teaching/examinations/research);
- Other relevant skills (e.g. sign language, interpretation)
- Reason for interest in SP work;
- Willingness to participate in physical examination sessions;
- Photographs (head and shoulders and a full length image).

An example SP record form that can be held within a database is provided by (Tierney et al. 2015:95-97). In addition, an SP performance rating form may be completed by the facilitators and kept with an individual SP’s records e.g. stored within the department/organisation’s database. An example of a rating form for SP performance can be found in Tierney et al (2015:99), Tierney et al (2015:99) includes a 5 point-Likert scale rating to rate SPs against 9 domains:
• Response to student behaviours
• Accuracy of information given
• Accuracy of non-verbal behaviours
• Overall realism of role-play
• Appropriate positive feedback
• Wording and specificity of feedback
• Overall quality of verbal feedback
• Appropriate Likert scale feedback
• Appropriate written comments

Three other questions are included, that relate to aspects that were done well, suggestions for improvement and any other comments.

Recruitment challenges:
It is acknowledged that the recruitment suitable individuals capable of performing within the unique environment of healthcare SBE and high-stakes debriefings can be challenging (Pascucci et al, 2014). Within the North West of England there are many valuable sources of recruitment including: volunteer organisations, service user groups, professional acting agencies, local professional and community theatre companies, and colleges and universities with healthcare or performing arts programs.

Element 3: Training requirements

It is essential to establish clear local training arrangements for SPs involved in learning, teaching, assessment or research activities. Following the development of...
the SP3T course, it is envisaged that all staff involved in the training of SPs should be offered the opportunity to complete the SP3T e-learning and workshop.

It is acknowledged that training SPs and their facilitators carries specific resources considerations, is labour intensive and these should be factored into course/programme design and financial resource plans (Tierney et al. 2015).

The regional survey (section 3.1) identified that in the North West of England:

- Formal training is not always provided for SPs;
- Departments/organisations often rely on agencies to train their SPs for role portrayal;
- Where training is provided, it lacks consistency in duration, quality and content;
- There is no standardised training approach for SPs within academic assessment procedures.

The SP3T e-learning and workshop introduces the ‘SP common framework’ (figure 9 and section 4.1). The workshop builds on the knowledge acquired in the e-learning course relating to fundamental (methodology and evidence-based) SP practice, with a specific emphasis on:

- Writing SP roles;
- Training SPs for role portrayal;
- Training SPs to give feedback.

An additional regional ‘SP’ training course will be available from December 2015. This will provide a standardised, evidence-based training package to train anyone portraying the role of an SP (medical, non-medical, bands 1-4, pre-/post-registration students, actors, laypersonals, or service users). ‘Train The SP’ (2TSP) course aims to embed performing arts methodology within the standardised SP training package, to enhance the quality of the healthcare learning environment for existing and future workforce training and development.

**Locally developed training:**

Clear procedures for SP training, organisation, programme management responsibilities should also be developed to enhance the involvement of SPs in any learning activities. Locally developed training may also be provided, which is generic for a department/organisation. Consideration is required for the development of, and resource planning associated with the training of SPs for specific roles. This may include training SPs for specific role portrayal and departmental practices on the provision of feedback to learners in specific simulation activities. Examples of additional locally developed training may include:

- SP generic training relating to the integration of SPs within a department/organisation;
• SP specific role portrayal training (e.g. relating to specific case/assessments/research projects);
• SP feedback training related to specific learning/teaching/assessment requirements;
• Highly specialised SP intimate examination role training.

It is particularly important that SPs receive course/departmental/programme specific training if standardised performance is essential e.g. within academic/professional/high-stakes assessments (Adamo, 2003). Careful consideration is required when considering whether SPs are to be involved in education or academic examinations/assessments. During academic assessments/examinations SPs are commonly required to undertake the role of with little or no variation (standardisation), to enable a fair assessment of the participants’ knowledge and skills (Epstein, 2007). Whereas, when SPs are involved in teaching and learning activities, standardisation is not the primary concern, often spontaneous, unscripted interactions are permitted between the SPs and learners (Brody, 2006; Makoul, 2006; Pascucci et al, 2014; Tierney et al, 2015).

Consideration should be paid to the preparatory training (training prior to SPs arriving to participate in learning/teaching/assessment/research). In particular it is important to emphasise punctuality, commitment and communication between programme staff and SPs. Clear communication and dissemination strategies should be identified to ensure staff and SPs are aware of how role information and requirements are to be distributed within organisations/departments. It is also important to consider the ratio of SP trainers to SPs when developing and delivering local training (Tierney et al, 2015).
Element 4: Risk assessments

The development of transparent risk assessment procedures are advised to reflect simulation-based education activities. These may be an extension of existing SBE/separate risk assessments to specifically cover SP involvement within departments/organisations.

It is advisable to check with your organisation’s legal cover regarding risk assessment and other related policies that are required to cover volunteer or paid SPs. Additional policies may include cover for SPs in the case of accident/sickness/injury whilst volunteering/participating in paid employment within your department/organisation.

It is advisable to clarify with your organisation’s human resource/finance/legal department regarding the requirement of contracts for employment for SPs (whether voluntary or paid).
Element 5: Quality assurance procedures

By embedding clear quality assurance procedures, departments and organisations will be able to continually drive improvements in healthcare education involving SPs. To facilitate this process it is advised that clear (departmental/organisation) programme management policies and procedures are established, which outline the expectations of the course/programme. Components may include the development and evaluation of:

- Specialised training for staff and SPs,
- Recruitment, management and retention of SPs,
- SP performance evaluation (an example of a SP performance rating form available from Tierney et al, 2015:99),
- Provision of continual feedback which demonstrates the impact of SBE (learning/teaching/assessment/research) activities involving SPs (from staff, SPs and learners).

SPs can provide an invaluable contribution to the design, implementation, revision and growth of educational programmes (Nestel et al, 2011; Pascucci et al, 2014; Tierney et al, 2015). Quality assurance of SPs and their performance within SBE can be problematic and often neglected (Nestel, 2011; Tierney et al, 2015). In particular, under performance of SPs may not necessarily be formally documented. Healthcare and academic quality assurance procedures emphasise the importance of service user and learner feedback, thus it is considered good practice to evaluate and provide feedback to SPs. Peer review is common practice in academic institutions but may be less so in informal education occurring in healthcare organisations.

Thus, the concept of peer review/performance evaluation should be established as part of the locally developed training and clearly communicated to SPs during recruitment and training procedures (see SP common framework, element 2).
Feedback procedures, support and training following peer review or use of a ‘SP performance rating tool’ should be clearly communicated between SP trainers and SPs. The feedback and support offered should be documented and ideally stored in the SP database (see SP common framework, element 2).
4.2 Regional survey

The regional survey presented responses from 89 participants working within 24 different organisations including 4 HEIs and 20 NHS Trusts and 31 separate departments.

Variances in SP terminology, recruitment references, recruitment strategies, payment/expenses and reimbursement methods, provision of contracts and risk assessments and training provisions were identified. Training methods varied widely and despite working with SPs, over 1/3 of respondents were unsure of whether SP training was currently offered within their organisation. Fifteen percent also identified that despite involving SPs in healthcare educational activities, no specific training was provided for SPs. The challenges of developing SP training was also identified and included: capacity issues, cost saving issue means losing SP involvement, no training at present, time pressures and the variable quality of volunteers. A diverse range of SPs are currently involved in healthcare education across NW organisations including adults, children/newborn, interpreters, people with hearing/visual impairments, spinal injuries and learning disabilities. Equally SPs are reportedly involved in a diverse range of learning, teaching, assessment and research activities.

Only 14 respondents reported awareness of an SP database being available in their organisation. Respondents indicated specific database categories used within organisations, which were similar to those outlined by Nestel et al (2011). These categories will be used by the SP project team to develop an SP database in the second HENW forerunner project (Simulated Patients: blending performing arts pedagogy and healthcare education, March – December 2015).

Challenges relating to recruitment, involving SP in learning/teaching and assessments and maintaining quality assurance of SP involvement were identified. All of these factors were taken into consideration when developing the current SP3T programme learning and teaching resources (section 3.2.1) and SP common framework (section 4.1). The regional survey highlighted the current need and demand for specific SP training and the current challenges and limitations surrounding developing locally training for SPs and trainers were related to resource issues. Respondents also reported that specific SP training provision would be beneficial related to the following areas:

1. Writing SP roles,
2. Introduction to SP methodology,
3. SP programme development,
4. Training SPs to give feedback,
5. Training SPs for role portrayal,
6. Debriefing SPs,
7. Audio-visual use to support feedback/debrief,
8. SPs in interprofessional education,
9. Hybrid simulation (blended approach featuring SPs and part-task trainers)
10. SPs in nursing, physiotherapy, allied healthcare and paramedics,
11. Children SPs,
12. Moulage.

Items 1 to 5 have already been addressed by the SP3T programme (section 3.2.1, figures 2 and 3). The remaining 7 items are topics which could be developed in the future, to provide a holistic SP programme for SP trainers in the region.

4.3 SP3T e-Learning course
The SP3T e-learning course was positively reviewed by all eighteen pilot participants (SP trainers). The depth of information and content was considered appropriate. The content was deemed appropriate for novice and experienced simulation facilitators, although some reported that those with little experience may have difficulty providing detailed answers to some of the activities. Participants particularly valued the ‘stop and think’ activities.

Fourteen participants (88%, 14/18) reported difficulties viewing the online resources. The majority of difficulties reported related accessibility restrictions on NHS facilities. The inability to access the online resources on NHS IT facilities was reported by 44% (8/18) participants, which meant that the course had to be completed at home. Additionally, participants reported that the problems related to their Trust hardware not having the appropriate version of Internet Explorer (IE version 9 required, whilst Trusts are currently limited to version 7 due to other healthcare software programme operating requirements restrictions being applied across all NHS Trusts). The course participants from HEI organisations, did not experience these reported difficulties. Participants perceived that the e-learning resources were easy to navigate, resources content was useful, appropriate to their role as an SP trainer, and provided in appropriate depth and detail.

The reported navigation difficulties and layout issues have been addressed in the e-learning packages and in the newly developed Moodle book format. Both options are available and already hosted on the NWSEN, SP3T Moodle area. Suggested improvements have also been factored in the final SP3T resources (section 3.2.1 and figure 3). All of the e-learning course material has been updated following completion of the pilot. The learning and teaching resources have been developed in accordance with UK accessibility requirements (DDA, 1995; SENDA, 2001; Direct Government, 2010; The Equality Act, 2010; TechDIS, 2012a, 2012b; The University of Bath, 2012; Cullen and Roche, 2012).
4.4 SP3T Workshop
Focus groups were conducted at the end of the SP3T pilot workshop to allow SPs and workshop participants the opportunity to communicate, exchange anecdotes and remark on each other’s experiences and points of view. All of the SPs and participants commented positively about the SP3T workshop. The findings are explored below:

4.4.1 Simulated Patients’ perspective
All of the SPs involved in the SP3T both pilot workshops noted that the workshop differed from any SP training they had previously received, highlighting the uniqueness of the SP3T course. Some of the SPs had not received any formal training before and others stated that SP3T was better than training they had been involved in previously. All of the SPs noted a difference between pilot 1 and pilot 2; they related this improvement to clear training delivery, and noted that the course participants in pilot 2 seemed to be of better quality and more confident than those in pilot 1. However, this improvement could also be attributed to the course facilitators growing in confidence as their familiarity with the SP3T course delivery increased.

When reflecting on the SP3T course delivery methods, the SPs revealed mixed views. Some felt the balance between didactic teaching and practical work was fair and balanced, however, others felt there was more focus on the PowerPoint slides than the practical work. However, it was noted that the SPs all preferred practical methods of teaching and learning, including demonstrations, and they realised that they were not included in all aspects of the workshop, so could not draw any valid conclusions. In addition, the SPs were not actively participating in the workshop as a learner; they were there to aid the learning of the participants, which alters the perspective somewhat. Learners themselves felt that the balance was acceptable; highlighting that the balance between PowerPoint and practical work was one of the positive elements.

The SPs made some useful suggestions regarding learning resources to improve the SP3T workshop. Overall, they felt that the SP3T workshop was well structured, in-depth and comprised clear training delivery.

4.4.2 Workshop participants’ perspective
There was variety in the learners’ simulation-based education experience, facilitation and debriefing skills. This was verified by the SPs, who also noted the importance of learners completing the e-learning prior to workshop attendance.

While discussing their experience of the SP3T workshop, participants from both pilot dates highlighted four key elements: differences of opinion, suggested improvements, new knowledge acquired and positives. As with any group, there will always be differing opinions. Within this category the key point to note is the new knowledge that
learners acquired. Through participation in the SP3T workshop learners developed a clear understanding of the role SPs can play within simulation based education, and in addition to this, the risks associated with this role. Furthermore, they noted suggestions for safeguarding both SPs and students. The workshop participants were already working with SPs or had the intention to embed SP methodology into their simulation practice; through participation in the SP3T training course, they developed a new-found realisation of the importance of learning outcomes in scenario design and development. During the focus groups, workshop participants also made some suggestions on how to improve the SP3T workshop, which have been taken into consideration.

Figures 8 and 9 illustrate that the workshop participants' over-arching feelings towards the delivery methods used in the SP3T workshop were positive. Six of the basic themes were noted by both groups of participants (demonstrations, experiential learning, balance, continuity, products and follow-up), indicating a correlation between the perspectives of both groups. Participants from both focus groups also commented on the timing and pace of the workshops, suggesting that more time was required to assimilate all of the information provided. Furthermore, one participant suggested that a longer course duration was required as the information was so detailed. Problems identified with the e-learning package correspond with the findings of the e-learning evaluation survey (section 3.3.1). Problems with the e-learning package identified in the focus groups have been rectified (appendix 5) and suggested improvements to the delivery methods for the SP3T workshop have been incorporated.

4.5 Recommendations
Based on the findings of the pilot study, it is recommended that a pre-requisite requirement for attending the SP3T workshop is that the SP trainer firstly completes all elements of the SP3T e-learning course and submits their workbook prior to enrolment on the SP3T workshop by NWSEN.

Completion of all elements of the e-learning course is possible via Moodle, where user access and completion of activities is recorded. A Moodle assignment area is available to allow SP trainers to upload their completed workbook prior to attending the SP3T workshop. Once the workbook is uploaded, it can be verified as complete or incomplete (missing/insufficient detail in the activities). When a workbook is considered incomplete, resubmission is permitted. The proposed process is as follows:
The pilot highlighted differences in trainers’ skills, understanding of the individual SP3T topics and ability of trainers to develop and train SPs for both role portrayal and how to give feedback. This needs to be taken into consideration by following the process outlined in figure 11, to ensure that only appropriate individuals are enrolled onto the SP3T programme. In addition, the above process (figure 11) allows for greater quality assurance of future SP3T course delivery by NWSEN. Furthermore, SP3T materials and programme resources (figure 3) must be reviewed and updated regularly, in accordance with contemporary simulation-based education literature.
4.6 Further dissemination

The SP3T project has been disseminated at the Health Education North West Stakeholder Forum on 3rd March 2015 at the Macron Stadium, Bolton. An oral presentation, poster, banner and exhibition of resources were presented (see appendix 7.1 and http://nw.hee.nhs.uk/2015/03/06/stakeholder-forum-3rd-march/).

Two workshops entitled ‘Bringing simulation to life: involving Simulated Patients to support healthcare education’ are to be held at Brooks Building, Birley, MMU on the 8th and 10th June 2015. These workshops are intended to enable those involved in SBE to find out more about the ‘Simulated Patient Common Framework’, learn how to develop simulated patient roles, and gain top tips for training simulated patients for role portrayal. Eighty free places have been made available as per the project plan. The flyer for this event is provided in appendix 7.2. The workshops have been advertised throughout the region via NWSEN, MMU CPD networks and SP3T course participants. Over 60 of the 80 dissemination workshop places have already been booked, 2 weeks after initial advertising commenced (numbers accurate as of 29th April 2015). Contact details will be gathered at the event to provide outline details of interest in completion of the full SP3T programme for NWSEN. From this information, future SP3T workshops can then be planned for delivery in 2015 by NWSEN.

4.7 Implications arising from the project

The project has formed an international community of practice, surrounding the development of a bespoke SP Train-The-Trainer programme (Lave and Wenger, 1991). The project team will continue to develop further SP resources through the next project ‘Train-The-SP’ (2TSP) course, which aims to embed performing arts methodology within the standardised SP training package, to enhance the quality of the healthcare learning environment for existing and future workforce training and development.

The SP common framework now holds an ‘attribution-non-commercial-no derivatives creating commons licence. Further discussion is required to ensure that this is the correct form of protection for the intellectual property generated within this project.


This license only allows download of the SP3T common framework and it to be shared with others as long as they credit the above team. It cannot be changed in any way or used commercially.
The project team have handed over the Simulated Patient Train-The-Trainer programme to NWSEN; the e-learning package is hosted centrally on their virtual learning environment (Moodle), for all members of NWSEN to access. NWSEN have agreed that they will manage the SP3T programme and deliver the face-to-face workshop training to Simulation Trainers in the North West of England. Key considerations following the finalisation of the SP3T programme resources includes:

- Sustainability of the delivery of future SP3T workshops,
- Management of the SP3T e-learning VLE area,
- Verification of completion of SP3T e-learning course and submission of the workbook and enrolment onto SP3T workshop (as per the process outlined in figure 11),
- Ensuring that the resources and learning materials are maintained up to date and all hyperlinks checked on a regular basis by NWSEN.

Further discussion will be required to ascertain the options of delivering future SP3T workshops via NWSEN, including capacity, venue, staffing and quality assurance of facilitators delivering the workshops. Information gathered at the dissemination events in June (section 4.6) will be passed to HENW and NWSEN, to help establish a clear strategy for future delivery including resource and capacity planning to ensure quality assurance of future SP3T programme delivery.

Throughout the survey and pilot of the SP3T programme, respondents have referred to the ‘use of SPs’. During the pilot workshops, the correct terminology of ‘involving/working with SPs’ was emphasised and participants were reminded that SPs are individuals, not objects. The ‘involvement of SPs’ in healthcare education is becoming more formally recognised in the literature and will be further promoted at the dissemination workshops in June. This will also be addressed in future dissemination of the SP3T project including the HENW eWIN case study and journal article publications.

All future project information, updates and events will also feature on the project website: [www.mmu.ac.uk/simulatedpatient](http://www.mmu.ac.uk/simulatedpatient).
5.0 Conclusions

This project has developed, piloted and evaluated a bespoke Simulated Patient Train-The-Trainer (SP3T) programme for Simulation Trainers in the North West of England.

To achieve the overall aim, this project utilised a sequential exploratory mixed methods design, combining quantitative and qualitative data for comprehensive analysis. Firstly, the evidence base was explored to develop a regional questionnaire-based survey and later develop course resources. A regional survey was undertaken with 89 responses gained from 89 participants (working within 24 different organisations including 4 HEIs and 20 NHS Trusts and 31 separate departments). A needs analysis was conducted to establish capacity and demand (see section 3.1).

The overall aim of improve knowledge, awareness and best practice in relation to incorporating SPs within simulation-based education (SBE) or workforce development training programmes in the North West of England, UK has been achieved through a regional survey and four different evaluations of the pilot SP3T programme. The findings from a review of the evidence and survey were used to develop the bespoke standardised, evidence-based SP3T programme. The programme consists of a pre-requisite e-learning course and interactive workshop. Two pilot courses were delivered in February 2015. The evaluation of the e-learning and workshop components is presented in sections 3.3. The final SP3T programme resources include an e-learning course (Virtual Learning Environment (VLE) layout map, 5 e-learning packages, 2 Moodle books, videos and images, e-learning workbook and SP3T e-learning certificate of completion) and SP3T workshop resources (SP role templates, SP feedback templates, workshop course outline, PowerPoint learning and teaching resources, staff briefs including instructions for practical demonstrations and SP3T workshop certificates of participant attendance and Trainer facilitation) (section 3.2.1 and figure 3). All of the resources have been provided to the North West Simulation Education Network (NWSEN) and are currently housed on their (Moodle) VLE. Two additional e-learning Moodle books were developed following the pilot study feedback relating to access issues on NHS computers.

Eighteen SP trainers have now fully completed the SP3T e-learning and workshop programme. Feedback from the 18 participants (from 16 different organisations across the North West of England) and 5 SPs has been incorporated to further develop the SP3T course resources and SP common framework (section 4.1).

The SP common framework (section 4.1) and associated SP3T programme (section 3.2.1) has been designed to empower simulation trainers to effectively work with SPs in education and training, and ultimately lead to improvements in patient safety. The Simulated Patient Common Framework now allows simulation providers and trainers with a reference point from which to guide their work with SPs. This, in turn, should
encourage simulation trainers to maximise the potential of embedding SPs in their practice.
References


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Appendix 1: Regional Survey

Simulated Patients: a standardised, quality assured approach to training and implementation

You are being invited to take part in a research study.

Study purpose: To gather information from organisations on their experiences of working with Simulated Patients (SPs) in the North West of England.

For the purpose of this survey we have defined SPs as real people trained to portray patients and to give feedback to learners on their interactions. SPs used in simulation-based education help to provide a safe environment for the 'patient' and learner.

Aim of the study: To improve knowledge, awareness and best practice in relation to the integration of SPs within Simulation Based Education (SBE) or workforce development training programmes in the UK.

Study Objectives:
• To gather information from Simulation Providers who work with SPs in the North West of England
• To identify evidence on key elements, including; recruitment, payment, expenses, contracts, risk assessment, and terminology (service users, standardised patients, simulated patients, patient volunteers)

Why have I been chosen? You have been invited to take part in this study as you are currently a member of the North West Simulation Education Network (NWSEN) or you work within a university or organisation in the North West of England.
Participation Information

Participation: The questionnaire should take no more than 15 minutes to complete and consists of questions relating to your experiences of integrating SPs in SBE. Participation is voluntary and no monetary payments will be made.

Benefits of participation: Findings from this study will be used to inform the development of a bespoke ‘train the trainer’ programme for the UK, which will be piloted in the North West of England in partnership with NHS Trusts and the North West Simulation Education Network (NWSEN).

Confidentiality: Your confidentiality will be protected; you will not be required to identify your name or other personal identifying information on the online questionnaire. You will only be asked to provide the name and department of the organisation you work for to identify multiple respondents. This information will be kept confidential.

You are able to provide a unique identification number to enable the withdrawal of your data. You are free to withdraw your questionnaire at any time until the data is to be analysed, without any threat to you or the study.

Computer records will be password protected. The completed questionnaires and the data generated from them will be kept for 5 years and then confidentially destroyed.

Results: Data provided by this study will be analysed and included within study evaluation report, and in future peer-reviewed publications and/or conference presentations.

Funding: This study is organised by the Principal Investigators, Suzanne Gough and Leah Greene from Manchester Metropolitan University on behalf of Health Education North West (HENW).

Ethical Approval: Ethical approval has been sought and gained from Manchester Metropolitan University internal ethics committee (Ref. No. 1254).

Contact for Further Information
Mrs Suzanne Gough, Senior Lecturer in Physiotherapy Department of Health Professions, T:0161 247 2942 Email: s.gough@mmu.ac.uk

Mrs Leah Greene, Senior Lecturer in Clinical Simulation, Departments of Health Professions & Nursing, T:0161 247 2515 Email: l.greene@mmu.ac.uk

Faculty of Health, Psychology and Social Care, Manchester Metropolitan University
Consent

1. Do you consent to participate in this study entitled: Simulated Patients: a standardised, quality assured approach to training and implementation?
   - Yes
   - No

2. This is an option for you to provide a unique identification number to assist with the withdrawal of your data if you wish to do so prior to data analysis.
3. What type of organisation do you work for?

☐ Primary Care
☐ NHS Secondary Healthcare (i.e. hospital)
☐ North West Ambulance Service
☐ Private Hospital
☐ Dental Hospital/Practice
☐ General Practice
☐ Higher Education Institution
☐ Professional Council
☐ Other (please specify)

4. Please provide the name and department your organisation.

(This information will only be used to identify multiple responses from the same organisation and not to identify you as an individual)
Terminology - This section aims to establish the common terminology used within the region relating

Throughout this survey the term 'Simulated Patient' refers to any of the following:

Standardised Patient (a real person trained to portray a patient in a clinical simulation scenario)

Service User (a current or past user of health and social care services)

Embedded participant (a person assigned to a role in a simulation encounter to help guide the scenario, e.g. simulated relative)

Electronic/Virtual World Simulated Patient

5. Do you currently work with or involve Simulated Patients within your organisation?

- Yes
- No
6. Which of the following terms does your organisation use to describe Simulated Patients? (please tick all that apply)

- [ ] Simulated Patient
- [ ] Standardised Patient
- [ ] Service User
- [ ] Embedded participant
- [ ] Electronic or Virtual Patient (e.g. Avatar in Second Life)
- [ ] Other (please specify)

[Box for other]
Recruitment

This section aims to establish the range of recruitment strategies used within the region to recruit Simulated Patients.

7. Where does your organisation recruit Simulated Patients from? (please tick all that apply)

- Personal referral (e.g. from staff, educators, medical schools)
- Referral from specialised actor agencies
- Recruitment from Service User Groups
- Advertisement (e.g. information on your organisation's website)
- Amateur dramatic group
- Other (please specify)

8. How are Simulated Patients recruited in your organisation? (please tick all that apply)

- Personal referral
- Application form only
- Application form and telephone interview
- Application and face to face interview
- Other (please specify)
9. Are there any challenges when trying to recruit Simulated Patient involvement in your organisation?
   ○ No
   ○ Yes

Please feel free to provide any further details in the box below

10. Which of the following people does your organisation work with as Simulated Patients? (please tick all that apply)
    ○ Children
    ○ Adults
    ○ Learning Disabilities
    ○ Mental Health
    ○ Interpreters
    ○ Visually Impaired
    ○ Hearing Impaired
    ○ Other (please specify)

11. Do you currently hold a database of Simulated Patients within your organisation?
    ○ No
    ○ Unsure
    ○ Yes (please list the categories of data held e.g. Age, gender, willingness to participate in assessment, suitable roles, roles played, training received)
12. What is the principal focus of involving Simulated Patients for the education of staff or students in your organisation? (please tick all that apply)

☐ Teaching (Undergraduates)
☐ Teaching (Postgraduates)
☐ Teaching/Assessment of physical examination
☐ Teaching/Assessment of intimate examinations (e.g. breast)
☐ Assessment (Undergraduates)
☐ Assessment (Postgraduates)
☐ Short courses
☐ In-house continuing education courses (CPD/local training)
☐ Participation in research projects
☐ Piloting simulation-based training/short courses
☐ Quality assurance
☐ Other (please specify)

13. Please provide examples of how Simulated Patients are involved in simulated activities within your organisation (e.g. types of scenarios/assessments/courses)
14. Are there any challenges associated with maintaining quality assurance for Simulated Patient involvement within your organisation? (please tick all that apply)

☐ Setting standards for recruitment
☐ Training
☐ Feedback process (to the teaching faculty)
☐ Time pressures
☐ Payment
☐ Other

If you have ticked any of the above, please provide brief details
Payment and Expenses

This section aims to establish the range of payment strategies offered within the region when Simulated Patients contribute to education provision featuring simulation.

15. How are Simulated Patient's compensated for their time? (please tick all that apply)

- Organisation funds available (e.g. for teaching and assessment purposes)
- Research project funding (e.g. government, research bodies or commissioning institutions)
- Flat rate (e.g. half or full day)
- Hourly rate provided
- Vouchers offered
- Travel expenses reimbursed
- Set travel expenses provided
- Voluntary - no payment or expenses
- Voluntary - travel reimbursed only
- Unsure
- Other

Please provide exemplar details of payment options (e.g. hourly rate, flat rate, typical expenses, minimum payments or value of vouchers offered) in the box below.
This section aims to establish the extent to which contracts are offered to Simulated Patients contributing to education provision featuring simulation.

16. Does your organisation provide a formal contract for each Simulated Patient involved in the education provision of staff or students?

- Yes
- No
- Unsure
Risk Assessment:

This section aims to establish whether documented risk assessments undertaken regarding Simulated Patient contribution to education provision featuring simulation.

17. Does your organisation have risk assessment documentation for the involvement of Simulated Patients?
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

Please feel free to provide any further details in the box below
Simulated Patients - October 2014

Simulated Patient Training

The purpose of this section is to establish the current methods and diversity of training provided for Simulated Patients involved in the education provision for staff and students within the region.

18. Does your organisation offer any of the following? (please tick all that apply)

- General training prior to any involvement
- Mandatory training programme
- Refresher sessions offered
- Additional sessions provided for sessions specific requirements (e.g. involvement in assessment)
- Specific training on 'how to give feedback to participants'
- Specific role training (e.g. session specific)
- Other
- None
- Unsure

Please feel free to provide any further details in the box below


19. Which of the following methods of training are offered to new Simulated Patients within your organisation? (please tick all that apply)

- [ ] Face to face training
- [ ] E-Learning
- [ ] Workshops
- [ ] None
- [ ] Unsure
- [ ] Other

Please feel free to provide any further details in the box below

---

20. Are there any challenges when developing training for Simulated patients working in your organisation?

- [ ] No
- [ ] Yes

Please feel free to provide any further details in the box below

---
21. Which of the following Simulated Patient online training resources would be of benefit to you in the future? (please tick all that apply)

- [ ] Introduction to Simulated Patient Methodology
- [ ] Simulated Patient programme development
- [ ] Writing Simulated Patient roles
- [ ] Training Simulated Patients for role portrayal
- [ ] Training Simulated Patients to give feedback
- [ ] Audiovisual use to support feedback/debrief
- [ ] Hybrid simulation (blended approach featuring Simulated Patients and part-task trainers/augmented reality)
- [ ] Moulage
- [ ] Debriefing Simulated Patients
- [ ] Simulated Patients in nursing, physiotherapy, allied healthcare, paramedics
- [ ] Simulated Patients in Interprofessional Education
- [ ] Children Simulated Patients
- [ ] None
The End of the Survey

We would like to thank you for your participation in this survey.

If you would like to know more about the regional 'Simulated Patient Train-The-Trainer' project or participate in the associated pilot study, please email either of the Principal Investigators: Suzanne Gough (s.gough@mmu.ac.uk) or Leah Greene (l.greene@mmu.ac.uk).

22. Please feel free to provide any comments in the box below.
Appendix 2: e-Learning Survey

Welcome

This is a short survey to evaluate the usability of the Simulated Patient Train-The-Trainer (SP3T) e-learning material.

1. Did you have any difficulties viewing the SP3T online resources?
   - Yes
   - No
   - If yes please specify

2. Please rate the following statements:

<table>
<thead>
<tr>
<th>How easy did you find it to open the individual section resources?</th>
<th>Very difficult</th>
<th>Difficult</th>
<th>Neutral</th>
<th>Easy</th>
<th>Very easy</th>
</tr>
</thead>
<tbody>
<tr>
<td>How easy did you find it to navigate between the sections?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide more information on any issues
3. Please rate the following statements regarding the layout of the online resources:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The layout of the individual sections (e.g. Section 1: SP methodology and common framework) was easy to read</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Please provide comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The layout of the individual sections (e.g. Section 1: SP methodology and common framework) was easy to use (navigate)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Please provide comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The colours used were easy to read</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Please provide comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Please rate the statements relating to the content of the online resources:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The content of the online resources was aimed at the appropriate level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The content was appropriate for my role</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The content was of sufficient detail</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not feel that it is necessary to record my answers for future</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reference (for CPD/revalidation purposes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found the learning activities useful (The stop and think activities)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I thought that the material was too in-depth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide additional comments regarding course content
Appendix 3: Focus group questions

For SP3T pilot course participants only:

1. Tell me about your experience during the workshop today...
   Prompt - which elements did you like/dislike?

2. Tell me about the style of delivery of the workshop...
   Prompt - how do you feel about the balance between presentation/group activities?

Prompt – consider the following:
- Preparation of SPs for role portrayal and practicalities of the method
- Teaching SPs to deliver quality constructive feedback in patient focused simulations

For SPs only:

1. How has the training you have received today differed from any previous SP training you've experienced before

2. Tell me about the style of delivery of the workshop...
   Prompt - how do you feel about the balance between presentation/group activities?

Prompt – consider the following:
- Preparation of SPs for role portrayal and practicalities of the method
- Teaching SPs to deliver quality constructive feedback in patient focused simulations.
Appendix 4: One month-post-course implementation survey

Simulated Patient Train-The-Trainer (SP3T) Implementation Survey

Introduction

The final stage of the SP3T evaluation is to ascertain the extent of applied learning from the e-learning and workshop.
Please take a few minutes to answer the following 5 questions.

* 1. Please indicate the extent of any change in practice as a result of completing the SP3T programme.

<table>
<thead>
<tr>
<th>No change(s) in practice</th>
<th>Change(s) required but not yet planned for</th>
<th>Already planning change(s)</th>
<th>Implemented change(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simulated patient (SP) recruitment strategies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SP selection process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource considerations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SP training requirements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SP risk assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality assurance procedures (relating to involving SPs in your area of practice)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

* 2. Are there any anticipated challenges/barriers to implementing changes relating to any elements of the SP common framework in your area of practice? (SP common framework includes recruitment and selection processes, resource considerations, training requirements, risk assessment and quality assurance procedures).

- Yes
- No

Comments:
**3. As a result of completing the course, please rate the following statements: 'I know how to...'

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write an SP role using the structured SP3T template</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Embed the SP role into a simulation scenario</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Train SPs for role portrayal</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Train SPs to give feedback (as part of the debrief)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments:

**4. As a result of completing the course, please rate the following statements: 'I have greater confidence in my ability to...'

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop SP roles</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Train SPs for role portrayal</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Train SPs to give feedback</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments:
* 5. Since completing the SP3T programme, have you used any of the training elements in your area of practice?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not applicable (in my current role)</th>
<th>Planning on using but not had the opportunity to do so yet</th>
</tr>
</thead>
<tbody>
<tr>
<td>SP3T role template</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 stage process of SP training (Person, learning activity, context, rehearsal, feedback)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embedding SP feedback to the learner (as part of the debrief)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inviting feedback from SPs for quality assurance purposes (e.g. the role information, learning activity, timing or any training you have provided)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
Appendix 5: NWSEN Moodle (Virtual Learning Environment) Screenshots

Figure 1: Initial MMU Moodle testing area.
Figure 2: NWSEN SP3T access page (after secure logon with individual NWSEN membership details).
Figure 3: NWSEN Virtual learning centre SP3T course layout.
In the light of the access issues of the SCORM packages (e-learning work packages) generated and piloted in phase 2 (section 3.2), the team have now developed a series of Moodle books which can be used instead of the SCORM packages to eliminate access issues (figures 4-8).

Figure 4: MMU Moodle development area featuring SP3T E-learning Course Moodle Book 1.
Figure 5: SP3T E-learning book 1 with navigation page.
Figure 6: SP3T content example 1.

Figure 7: SP3T content example 2.
Figure 8: SP3T learning activity (the answers are then recorded by the participant’s workbook for submission, section 3.3).
Appendix 6: SP3T Workshop delivery images

SP3T ‘5 Stage Training Model’

Examples of trainers using the ‘5 stage training model’.

SP ‘Person’ development  Discussing the ‘learning activity’ and then ‘context’  ‘Rehearsal’

(Adapted from Nestel, 2008; Nestel, Fleishman, Bearman, 2015)
Appendix 7: Dissemination events

7.1 Poster for NHS HENW Stakeholder event – 3rd March 2015

Project outline

The purpose of this project was to develop, pilot and evaluate a bespoke Simulated Patient (SP) training programme.

The aim of developing the SPPT programme was to improve knowledge, awareness and best practices in relation to embedding SPs within simulation-based education or workforce development training programmes in the UK.

What we did

1. Literature review
2. A regional survey. Data was obtained from 80 participants, working within 24 identifiable organisations (3 HEIs and 23 NHS Trusts and 21 separate departments).
3. Developed an evidence-based SP common framework.
4. Developed the SPPT programme learning:
   - 10 e-learning packages
   - 10 role and method templates
   - SPPT workshop and associated digital learning and teaching resources
5. Pilot of the SPPT e-learning course and workshop

Evaluation and results

1. Findings from the literature review were used to develop the common framework and SPPT programme learning and teaching resources.
2. Findings from the regional survey were used to guide the development of the SPPT programme.
3. The SPPT e-learning pilot evaluation (n=30 participants) has been used to modify the learning resources. Issues with internist nurses in NHS Trusts were identified.
4. Two pilot workshops were delivered and evaluated by 4 focus groups (n=19 participants). Findings of the focus groups have been used to develop further resources.
5. A survey is due to be undertaken in March 2015 to evaluate the impact of undertaking the SPPT programme.

SP common framework

The SP common framework includes guidance on:
- SP training
- SP education
- Training materials
- Training environment
- Quality assurance

Project team

Ms Suzanne Gough, Ms Leah Greene, Mr Stuart Roberts, Ms Ann Natali, Visiting Professor Ralph MacKinnon, Mr Mark Hellaby, Professor Debra Nestel, Dr Neil Tuttie, Professor Brian Webster
Bringing simulation to life:
Involving Simulated Patients to support healthcare education

Find out more about the Health Education North West Simulated Patient Common Framework, learn how to develop simulated patient roles, and gain top tips for training simulated patients for role portrayal.

There are 40 free places available at each event and registration is via the Eventbrite links below. Refreshments will be provided.

**Session one**
8th June, at MMU Brooks Building, Birley, twilight session
(5-8pm including buffet)
https://simulatedpatients.eventbrite.co.uk

**Session two**
10th June, at MMU Brooks Building, Birley, afternoon session
(1-4pm including afternoon tea)
https://simulatedpatients.eventbrite.co.uk

For further information on the project:
www.mmu.ac.uk/simulatedpatient

For informal enquiries, please email: enterprise.hpsc@mmu.ac.uk
## Appendix 8: Project expenditure 2014/15:

<table>
<thead>
<tr>
<th>Dates for spend 2014/15</th>
<th>Description of spend including counterparty</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Costs</strong></td>
<td><strong>Project Team:</strong></td>
<td><strong>£55,830</strong></td>
</tr>
<tr>
<td></td>
<td>- Suzanne Gough (£21,411)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Leah Greene (£21,411)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Stuart Roberts (£806 + additional RKE* hours from MMU)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Mark Hellaby (£4147)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Neil Tuttle (£2773)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Brian Webster (£1025)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Debra Nestel (£2919)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Service User (£1338)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Ralph MacKinnon (£0; use RKE* hours from MMU)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Carol Taylor (£0; use RKE* hours from MMU)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Rachel Spearing (£0; use RKE* hours from MMU)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Janice Murray (£0; use RKE* hours from MMU)</td>
<td></td>
</tr>
<tr>
<td><strong>Online survey platform</strong></td>
<td><strong>Survey Monkey Gold £299 per annum</strong> (<a href="https://www.surveymonkey.com/pricing/?ut_source=sem">https://www.surveymonkey.com/pricing/?ut_source=sem</a>)</td>
<td><strong>£299</strong></td>
</tr>
<tr>
<td><strong>Consumables</strong></td>
<td><strong>Course document printing during development and project report writing phases.</strong></td>
<td><strong>£1000</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Marketing of master class</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Pilot Delivery Costs</strong></td>
<td><strong>2 days venue hire and refreshments, free Wi-Fi and parking (£780/day/20 participants, NWSEN training room Birchwood Centre, Warrington)</strong></td>
<td><strong>£1560</strong></td>
</tr>
<tr>
<td><strong>Project Impact Master Classes</strong></td>
<td><strong>2 x 1/2 day venue hire and refreshments, free Wi-Fi and parking (£560/half day/40 participants, NWSEN training room Birchwood Centre, Warrington)</strong></td>
<td><strong>£1120</strong></td>
</tr>
<tr>
<td><strong>Simulated Patients</strong></td>
<td><strong>Payment for attending pilot study days (SP hourly rate of £30 per hour/SP for 4 hours each) This rate is modelled on UK SP costs highlighted in Nestel et al. 2011. 10 SPs will be required on each of the 2 pilot training days and project impact Masterclass).</strong></td>
<td><strong>£3000</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Travel costs—the standard mileage rate (45p/mile or alternative mode of transport costs) from Greater Manchester Region to the NWSEN training site at Birchwood Centre, Warrington (up to a maximum of £30).</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>£62,809</strong></td>
</tr>
</tbody>
</table>

*RKE = Research Knowledge Exchange.*