ASPiH

ASSOCIATION FOR SIMULATED PRACTICE IN HEALTHCARE

Simulation Activity in Health Education and Care Sectors

Report from the 2024 National Simulation Survey

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Acknowledgements

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Dr Kevin Stirling led on the design, delivery, and evaluation of this study on behalf of ASPiH.

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Executive Summary

This report presents findings from the ASPiH survey conducted across the UK and Ireland in 2024. The insights shared here are based on the perspectives of those who responded (n=107). While the survey does not capture the full breadth of views across the simulation community, the themes identified provide valuable prompts for reflection and action, and the call to action outlined in this report reflects these respondent perspectives.

This summary highlights the key themes, challenges, and proposed solutions from the ASPiH National Simulation Survey, offering insights into the current state of simulation activities across health and care settings. It aims to support stakeholders in strategically planning and implementing simulation activities which demonstrate their impact on healthcare education, clinical practice, and most importantly patient outcomes.

By comparing data from 2014 and 2024, the survey highlights persistent barriers that have hindered the wider adoption of simulation, as well as factors that have supported its growth, innovation, and resilience within healthcare education and practice within health and social care settings.

Data Collection

The survey was open to all individuals involved in the simulation community. While primarily focused on the UK and Ireland, responses were not geographically restricted. ASPiH and partner organisations promoted the survey over an eight-week period. A total of 107 responses were received (52% response rate compared to 2014). Five focus groups were held with representatives from NHS Trusts, Higher Education Institutions, Primary Care, and commercial organisations provided further insights. Discussions underscored the value of simulation, identified key challenges, and proposed solutions to improve its effectiveness across healthcare settings.

Results

1. Simulation is rarely integrated into organisational strategy or viewed as core business.
2. Underfunding of simulation persists, with many educators working beyond their contracted hours.
3. Access to faculty development training is inconsistent, with a lack of standardisation.
4. Human Factors and systems testing is valued but inconsistently understood and applied.
5. Logistical challenges and perceptions of inauthenticity hinder the wider adoption of interprofessional simulation.
6. The wider utilisation of XR, VR & AI are being hampered by high costs and limited evidence of educational benefit.
7. There is a continued lack of impact data with most evaluations being anecdotal on the day evaluations which are not systematically measured.

Call to Action

ASPiH encourages stakeholders in education and health and social care sectors to:

1. Advocate for Simulation to become an Organisational Priority

Simulation requires to be embedded in organisational strategy and workforce plans. Align activities with regulatory bodies (e.g., Nursing and Midwifery Council (NMC), General Medical Council (GMC), Health and Care Professions Council (HCPC)) to enhance credibility. Develop a national impact framework to measure and report return on investment (ROI) and return on excellence (ROE).

2. Funding and Resources

Secure protected simulation time in job plans across all professions. Establish processes for dedicated funding for infrastructure and staffing. Develop a national tariff model for simulated placements, including in regions currently

without such models (e.g., Scotland). Collaborate to develop sustainable funding models for simulation.

3. Faculty Development

Endorse and support faculty development programmes. Remove access restrictions to national faculty development programmes (e.g., allow access for independent and commercial providers). Create a modular, tiered development pathway aligned with ASPiH standards. Establish regional simulation hubs for shared training and mentorship.

4. Human Factors & Systems Testing

Issue guidance and case studies on integrating human factors into simulation design and debriefing. Promote the use of frameworks like SEIPS [1] for system-level analysis. Encourage simulation teams to collaborate with patient safety and quality improvement teams to develop meaningful solutions which report the impact of these endeavours.

5. Interprofessional Simulation

Promote and participate in interprofessional learning initiatives. Develop flexible, scalable scenarios for use across professions. Coordinate timetables across HEIs and NHS partners to facilitate joint simulation sessions. Co-design scenarios with all stakeholders to enhance authenticity.

6. Extended reality, Virtual Reality and Artificial Intelligence

Advocate for simulation activities to be embedded in organisational strategy and workforce plans. Align activities with regulatory bodies (e.g., Nursing and Midwifery Council (NMC), General Medical Council (GMC), Health and Care Professions Council (HCPC)) to enhance credibility. Develop a national impact framework to measure and report return on investment (ROI) and return on excellence (ROE).

[1] Holden R, Carayon P, Gurses A, Hoonakker P, Hundt A, Ozok A, Rivera-Rodriguez J. SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics. 56(11):1669-86.

7. Impact and Evaluation

Contribute to the evaluation and documentation of simulation impact. Collaborate with commissioners, Royal Colleges, and commercial companies to create a five-year simulation research strategy. Build a national repository of case studies and provide evaluation tools (ROI/ROE calculators). Establish a national mentorship network to support cross-sector research and evidence generation.

Expected Benefits

1. Enhanced strategic prioritisation of simulation within organisations.
2. Sustainable funding models for simulation activities.
3. Standardised and accessible faculty development pathways.
4. Improved integration of human factors into simulation design and debriefing.
5. Authentic and scalable interprofessional learning scenarios.
6. Evidence-based investment in immersive technologies.
7. Systematic evaluation and documentation of simulation impact.

The Association for Simulated Practice in Healthcare

Established in 2009, ASPiH is the leading body for simulation, technology-enhanced learning, and immersive simulation in the UK and Ireland. In its 16 years as a membership association, it has grown and evolved both in its activities that support our members and in its relationship with other societies and commercial partners in the wider simulation community. ASPiH delivered the first National Simulation Survey in 2014. The 2024 survey aimed to evaluate developments in simulation practices over the past decade.

ASPiH has published standards to support all individuals involved in the design, delivery, evaluation, and translation of simulated practice to deliver activities which are high-quality, safe, sustainable and promote equity, diversity and inclusion.

Each year, in November, ASPiH holds an annual conference and network meeting. The conference themes are chosen to help us explore, share and evaluate something that we feel is important, current or innovative. Our most recent conference in Edinburgh attracted over 800 delegates.

ASPiH delivered the first National Simulation Survey in 2014 [2]. The follow-up survey in 2024 was designed to assess progress in simulation activities in the intervening 10 years with particular attention to leadership, policy integration, and system-wide implementation.

Context and Purpose

The 2014 survey reported widespread use of simulation for technical skills training, with increasing curricular integration in undergraduate programmes. Simulation activities were rarely applied to human factors and patient safety, and public involvement in scenario design was minimal. The lack of national commissioning standards and fragmented leadership were identified as

critical barriers. These findings informed the development of the ASPiH Standards [3 4], which advocated for consistent simulation delivery and faculty development.

This 2024 study examined the evolution of simulation activities over the last decade, in the United Kingdom and Ireland, highlighting enduring barriers and key enablers across policy, practice, and professional development. Drawing on comparative data from 2014 and 2024, the study evaluates the spread, impact, and strategic integration of simulation and immersive technologies within health and social care settings.

Aims of the 2024 Survey

- To assess improvements in leadership approaches and governance of simulation activities.
- To understand how, where, and when simulation is used across the UK and Ireland.
- To gather examples of best practice and innovation.
- To identify persistent barriers to adoption and scale.

2. Association for Simulated Practice in Healthcare (ASPiH) 'The National Simulation Development Project: Summary Report'.2014. http://aspih.org. uk/wp-content/uploads/2017/07/national-scoping- project-summary-report.pdf
3. Purva M, Nicklin J. ASPiH standards for simulation-based education: process of consultation, design and implementation. BMJ Stel 2018; 4:103–111.
4. Diaz-Navarro C, Laws-Chapman C, Moneypenny M, Purva M. The ASPiH Standards - 2023: guiding simulation-based practice in health and care. 2023. https://aspih.org. uk/standards-2/

Methodology

Survey Design: 60 questions (mixed of closed and open response formats), based largely on the 2014 survey to allow for comparison. Additional questions captured perceived impact and innovation. A 'prefer not to say' option was inserted for every question to allow respondents to only answer questions that they felt comfortable with.

Distribution: Promoted via existing ASPiH membership, social media, and partner organisations over an eight-week period.

Data Collection: No personal data was collected within the survey; optional focus group invitations were issued at the end of the questionnaire. This was the only time that identifiable data was collected so that respondents could be invited to a focus group.

Ethical Considerations

Ethical approval was granted by Edinburgh Napier University's Centre for Higher Education Research (CHER, Approval Record Ref: 3832345). Participation was voluntary, with no incentives or remuneration offered. Responses were the opinion of the individual and were submitted without coercion from members of the ASPiH Executive Committee or any partner organisation. Participants could exit the survey process at any time without implication.

Participants

- Open to anyone involved in simulation activities within the UK and Ireland.
- No geographic restrictions were imposed in the survey design.
- Awareness was raised through ASPiH networks and partner organisations.

Results

The ASPiH national survey was open over an eight-week period between 16.09.24 and 11.11.24

Five focus groups were held between 27.01.25 and 17.02.25.

Overall, the 2024 survey received 107 responses which was a 48% lower response rate than the 2014 survey which received 206 responses.

Quantitative Analysis

Geographical Distribution of Survey Respondents (2014 vs. 2024)

Table 1 presents the self-reported locations of survey respondents in 2014 and 2024. It is important to note that the location question was not mandatory in the 2014 survey, which may have affected the response rate for this item.

Location	2014 (n=206)		2024 (n=107)	
	Number	%	Number	%
England	177	86%	72	67%
Northern Ireland	6	3%	18	17%
Scotland	19	9%	5	5%
Wales	4	2%	9	8%
Republic of Ireland	0	0%	3	3%

Table 1: Geographical Distribution of Survey Respondents

In both 2014 and 2024, most respondents were based in England. However, the 2024 data show a more geographically diverse respondent profile, with notable increases from Northern Ireland (rising from 3% to 17%), Wales (from 2% to 8%) and the Republic of Ireland (from 0% to 3%).

Conversely, responses from Scotland decreased, from 9% in 2014 to 5% in 2024. In 2014, Scotland benefited from a well-established regional network (The Scottish Clinical Skills Network), which actively supported simulation activity. Similar networks (such as the Yorkshire and Humber Simulation Network) existed in England. Many regional networks suspended activity during the COVID-19 pandemic, and some have not recommenced, which may explain reduced engagement from some regions in the 2024 study.

Employment Data of Survey Respondents

Table 2 reports the stated employer of survey respondents in 2014 and 2024 (this was not a mandatory question in 2014). The list of specialties was increased in 2024 to be representative of the ASPiH membership.

	2014 (n=191)		2024 (n=107)	
Employer	Number	%	Number	%
NHS (Secondary Care)	112	59%	38	36%
Higher Education	69	36%	28	26%
Primary Care	4	2%	10	9%
NHS (Critical Care)	0	0%	8	7%
NHS (Medical Specialty)	0	0%	7	7%
NHS (Surgical Specialty)	0	0%	5	5%
Educational commissioner	3	2%	4	4%
Commercial Company	0	0%	3	3%
NHS (Education)	0	0%	2	2%
NHS (No stated specialty)	0	0%	2	2%
Further Education	3	2%	0	0%

Table 2: Employer of Survey Respondents (2014 vs 2024)

Key Insights

- The NHS was the primary employer of respondents increasing slightly from 61% (2014) to 67% (2024).
- Representation from Higher Education Institutions decreased from 36% to 26%.
- Commercial and commissioning bodies have a modestly increased presence.

Simulation Faculty

In 2014, there was a lack of a coordinated approach to the development of simulation scenarios, which resulted in scenarios being developed on an ad-hoc basis or being developed by staff associated with a particular programme or clinical specialty. In 2024, 92% of respondents stated that they used relevant literature or data to inform the development of clear learning objectives which inform the design, delivery and evaluation of simulation activities. The inclusion of students or people with lived experience in scenario design remains limited Table 3 reports the composition of simulation faculty (respondents could select multiple options).

Faculty member	Number	%
A dedicated simulation faculty	72	26%
Clinical staff (from all professions)	72	26%
Experts with relevant experience	58	21%
Simulation technicians	35	13%
Students	22	8%
Patients (with relevant life experience)	13	5%
Commercial Partners	1	0%

Table 3: The composition of simulation faculty as stated in the ASPiH 2024 National Survey

In 2014, 24% of respondents reported that simulation faculty were required to undertake faculty development training before delivering activities. 71% indicated that faculty development training was recommended but either not consistently undertaken or delivered on an ad hoc basis. By 2024, there was a strong emphasis on faculty development, with structured training in scenario design, coaching, debriefing, and evaluation becoming more common. Table 6 outlines the types of faculty development programmes undertaken within respondents' areas of practice.

Type of faculty development training	Number	%
Face-to-face faculty development training programme	44	41%
In-house faculty development training programme	22	21%
Train the trainers course	14	13%
No faculty development training undertaken	11	10%
Mentorship from a simulation colleague	7	7%
Online faculty development training programme	7	7%
Prefer not to say	2	2%

Table 4: The types of faculty development training programmes as stated in the ASPiH 2024 National Survey

Key Insights

- There is a noted increase in consistency and rigour applied to of simulation scenarios.
- The number of untrained faculty has decreased significantly since 2014.
- There is a need to demonstrate the value of co-design in scenario development.

Professional Roles of Faculty

Professional role	Number	%
Doctor (Consultant, General Practitioner, Registrar and Fellow)	40	38%
Nurse (Lead nurse, Senior charge nurse, Charge nurse)	35	33%
Allied Health Professional (Physiotherapist, Operating Department Practitioners, Paramedic)	12	11%
Education role (Administrator, Lecturer, Simulation Lead, Professor)	10	9%
Simulation Technician	4	4%
Midwife	3	3%
Human Factors Specialist	1	1%
Pharmacist	1	1%

Table 5: Stated Professional Roles (2024)

Length of Service

The median length of time that survey respondents had participated in a simulation role was 8 years. The majority of respondents (45%) had participated in a simulation role between 6 – 15 years.

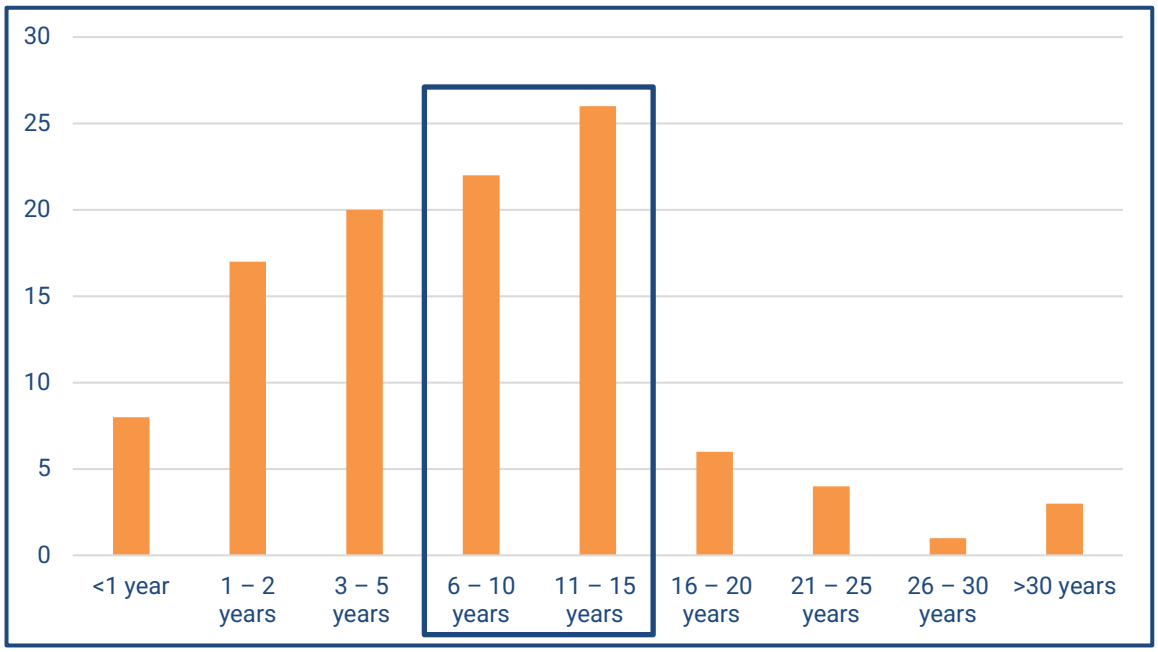

Figure 1:Length of service indicated in years

Time Allocation per Week

Respondents were invited to state proportion of their working week was allocated to simulation related activities (Table 6).

Hours/Week	%	Main Professional Groups
1 – 9	43%	Doctor (76%), Nurse/Midwife (13%), AHP (7%), Simulation specific (4%)
10 – 19	10%	Nurse/Midwife (64%), Doctor (18%), AHP (18%)
20 – 29	7%	Nurse/Midwife (38%), Simulation specific (25%), Doctor (25%), AHP (13%)
30 – 40	33%	Nurse/Midwife (49%), Simulation specific (23%), AHP (6%), Doctor (3%)
> 40	5%	Doctor (40%), Nurse/Midwife (40%), Simulation specific (20%)

Table 6: Total hours spent on simulation activities in a normal working week.

Leadership Roles in simulation

The role of simulation lead was identified in the 2014 study but no description of the responsibilities of this role were stated. In 2024, 34% of respondents self- identified as simulation leads. Most respondents described core responsibilities in relation to simulation activities which were practice related (delivery and operational aspects of service delivery).

Practice: Managing simulation programmes, centres, or faculty teams, increasing use of immersive experiences e.g. VR/AI.

Policy: Strategy development, alignment with regulatory frameworks (NMC/GMC/HCPC).

Professional Development: Faculty development /training, mentoring, and cross-institution collaboration.

Key Insights

- There is a noted increase in a defined leadership role in simulation teams.
- The number of untrained faculty has decreased significantly since 2014.
- There is a need to demonstrate the value of co-design in scenario development.

Funding and Utilisation

Funding

When comparing the range of commissioning bodies who funded simulation activities in 2014 and 2024 there was a noted increase in the range of commissioners in 2024 (Table 7).

Funding commissioner	2014 (n=192)		2024 (n=159)	
	Number	%	Number	%
NHS	112	58%	68	43%
Higher Education	68	35%	39	25%
Educational Commissioner	4	2%	17	11%
Ambulance Service	3	2%	6	4%
Further Education (College)	3	2%	4	3%
Primary care (Community)	2	1%	5	3%
Private Sector			4	3%
Regulatory Body			2	1%
Not commissioned			4	3%
Prefer not to say			2	1%
Commercial company			4	3%
Other (Government, Miliary, Not for profit)			4	3%

Table 7: Funding Commissioners (2014 vs 2024)

Utilisation

In 2014, the professional groups and disciplines most frequently engaged in simulation activities were postgraduate students in medicine, nursing, and dentistry (41%), followed by undergraduate students in the same fields (30%), NHS staff (23%), primary care staff (4%), and military personnel (3%).

Figure 2 presents comparative data from the 2024 survey, showing the types of professional groups involved in simulation activities and the frequency with which they undertake these activities.

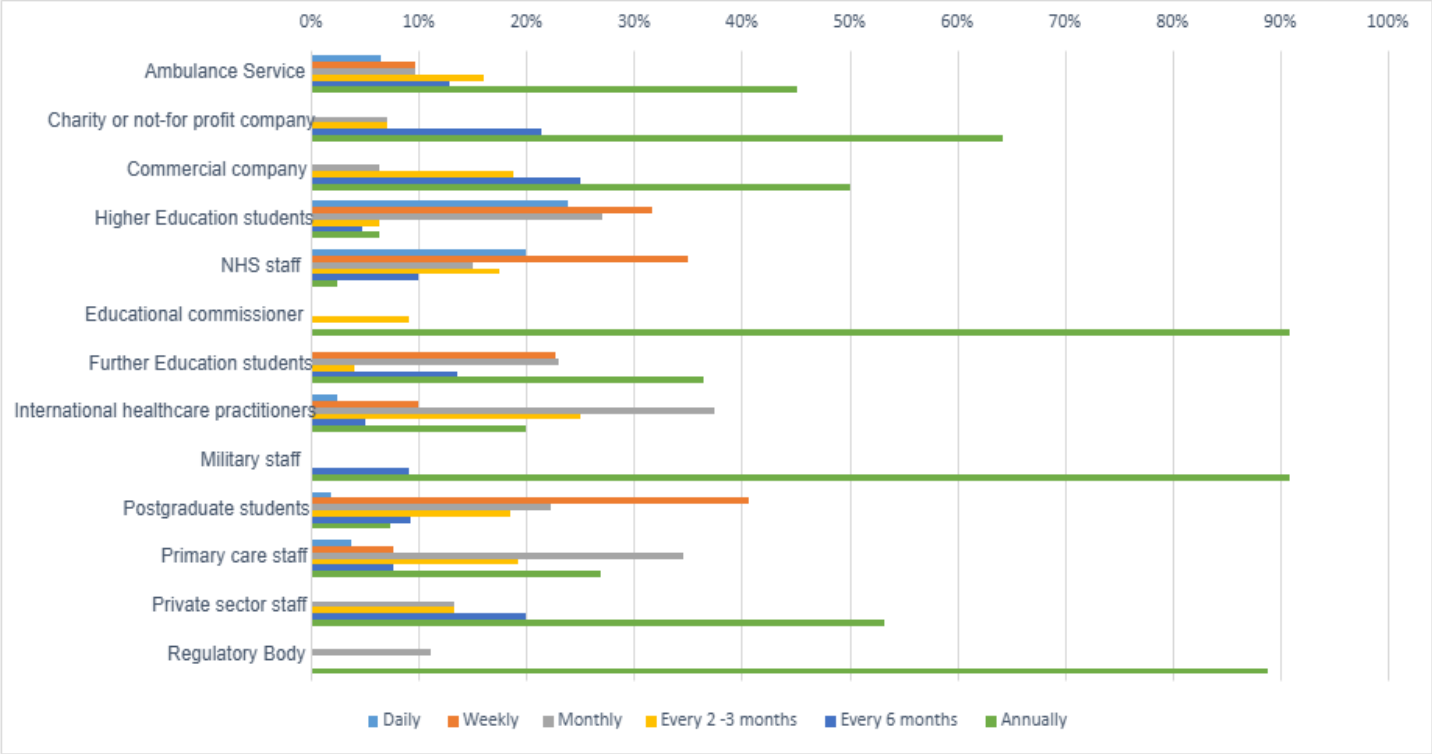

Figure 2: The types of professional groups and the frequency of when they undertake simulation activities as stated in the ASPiH 2024 National Survey.

Most Frequent Learner Groups

- Higher Education Students: Daily (24%), Weekly (32%)
- NHS Staff: Daily (20%), Weekly (35%)
- Postgraduate Students: Weekly (41%)
- Ambulance Services and Primary Care (Increasing frequency compared to 2014).

Key Insights

- Noted increase in the range of commissioning sources.
- 73% of respondents indicated a single source of funding for all simulation activity.
- 27% reported multiple funders for simulation activities.
- 45% of simulation activities involved >10 participants.

Location of Simulation Delivery

In 2014, simulation was primarily delivered in dedicated simulation facilities (33%). Other reported locations included in-situ settings (23%), teaching classrooms (23%), and advanced simulation suites (21%). Advanced simulation suites were defined as environments equipped with specialist equipment and supported by highly trained faculty.

By 2024, simulation was delivered across a broader range of settings, from simulation centres to highly immersive clinical and real-world environments such as hospital wards, GP practices, ambulances, and in-situ locations including courtrooms, stadiums, and roadsides. Figure 3 reports the utilisation for each location.

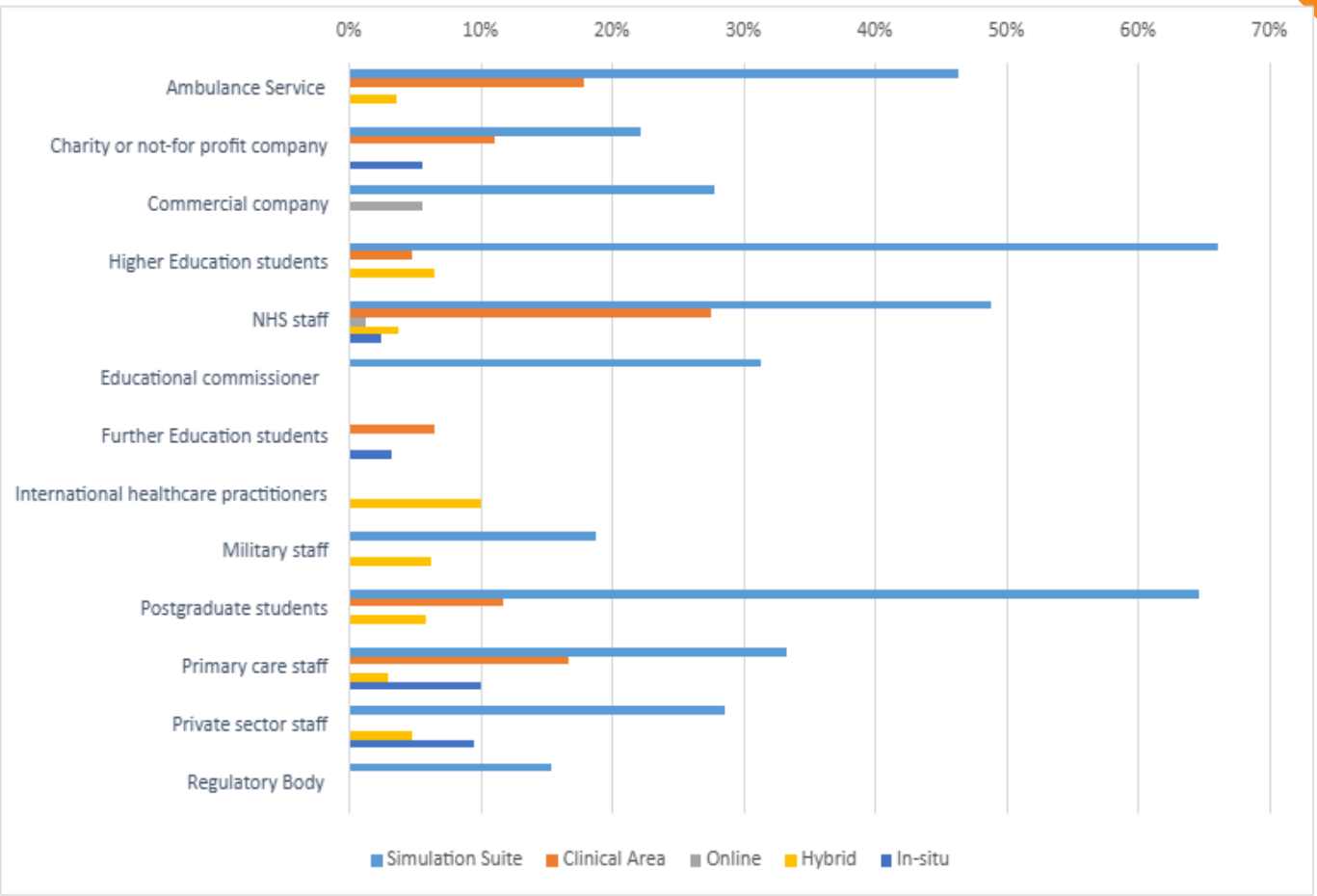

Figure 3: The frequency of utilisation for each location as stated in the ASPiH 2024 National Survey.

Key Insights

Growing use of simulation in diverse locations for:

- Commissioning of new services.
- System analysis/process improvement (utilising human factors frameworks)
- Addressing health inequalities and complex needs (e.g. neurodiversity awareness and mental health training.

Qualitative Analysis

There was limited data reported in the 2014 study which demonstrated the impact of simulation activities. A core objective of the 2024 study was to appreciate how, where and when simulation activities were being used and to understand the impact that these endeavours had on healthcare education or practice within health and care settings. Therefore, five focus groups were facilitated by the research team, comprising 16 participants across a range of settings: Higher Education Institutions (HEIs) in England (n=6), NHS Trusts in England (n=8; secondary care n=6, primary care n=2), Health and Social Care Northern Ireland (n=1), and a commercial partner (n=1).

All sessions were conducted via Microsoft Teams and recorded for analysis. Transcripts were reviewed for accuracy, anonymised, and assigned unique identifiers (e.g., Candidate 1, Candidate 2). The authors conducted independent thematic analyses and reached full consensus on key findings, resulting in 100% inter-rater reliability.

Core Themes

1. Simulation as an Organisational Priority

Challenge: Simulation activities are valued but not embedded within strategic priorities.

Despite being widely adopted in both HEIs and NHS settings, simulation is not consistently recognised as core organisational business. Many simulation programmes rely on simulation leads rather than structural support, with significant disparities in access, recognition, and investment—particularly within Primary Care. Respondents frequently described scenarios where they had to balance clinical duties and other professional obligations with their simulation responsibilities, often without any protected time within their job plans.

> *"It does feel like we're a bit of an afterthought from the organisation." Candidate 1, NHS Trust*

> *"The demand for simulation outstrips what we can actually deliver with the manpower that we've got." Candidate 7, NHS Trust*

Call to Action

- Integrate simulation into organisational strategies and workforce plans.
- Align simulation with regulatory standards (e.g., NMC, GMC, HCPC) to enhance visibility.
- Establish a national simulation impact framework to measure return on investment (ROI) and return on excellence (ROE).

2. Funding and Resource Constraints

Challenge: Chronic underfunding and reliance on voluntary effort.

Respondents reported a disconnect between leadership expectations and frontline realities. Simulation faculty frequently worked beyond contracted hours to meet delivery demands, without appropriate recognition or compensation.
65% of respondents reported experiencing significant resource challenges relating to time and workload pressures, insufficient funding and recognition, difficulties in recruitment and retention of faculty, and limited access to training and professional development opportunities within simulation teams.

> *"We're not being paid for that additional work… but we're being asked to do more and more." Candidate 7, NHS Trust*

> *"If we were to stick to the hours we're paid for, nothing would get done." Candidate 3, NHS Trust*

Call to Action

- Protect simulation time in job plans across all professions.
- Create formal mechanisms for dedicated simulation funding.
- Develop a national tariff model for simulated placements.

3. Faculty Development and Capacity Building

Challenge: Inconsistent standards and access to training.

While national standards for faculty development exist, access is inequitable. Content is not always multidisciplinary, and delivery is often dependent on goodwill. The absence of designated funding for faculty development was a recurring concern. Respondents stated that simulation roles were not formally acknowledged in appraisal processes, revalidation frameworks, or academic promotion criteria resulting in low morale and increased turnover.

> *"There's a lot of reliance on people giving up their own time."*
> *Candidate 8, NHS Trust*

> *"Everyone's doing their own thing… you only find out what's happening by accident."*
> *Candidate 9, HEI*

Call to Action

- Remove email domain restrictions for access to national training resources.
- Develop modular, tiered faculty development pathways which are funded and are aligned to ASPiH standards.
- Establish regional simulation hubs to promote shared delivery and mentorship.

4. Human Factors and Systems Testing

Challenge: Increasing relevance but inconsistent application.

Simulation is increasingly used to identify latent safety threats and test system resilience. However, many respondents lacked formal training in human factors despite employing its principles.

> *"We use [simulation] to understand what system issues affect team function."*
> *Candidate 16, NHS Trust*

> *"We wrote a new algorithm based on what we discovered through simulation."*
> *Candidate 6, NHS Trust*

Call to Action

- Develop clear case studies on integrating human factors in simulation activities.
- Promote frameworks like SEIPS to support systems thinking.
- Encourage cross-collaboration between simulation, safety, and QI teams.

5. Interprofessional and Multidisciplinary Simulation

Challenge: Logistical constraints and variable authenticity.

While interprofessional learning is valued, its implementation is challenging. Scenarios involving too many roles can feel artificial, while scheduling across professions remains a major barrier.

> *"Its really difficult without that strong evidence base. And particularly when we're looking at fields of practise where there isn't such a background of [IPL] simulation, for example mental health, nursing and learning disability nursing." Candidate 4, HEI*

> *"We've learned from trying to force this… now we reverse-engineer scenarios to include the right professionals." Candidate 5, HEI*

Call to Action

- Design flexible IPL scenarios for various settings.
- Align timetables across HEIs and NHS partners.
- Co-design simulations with input from all professional groups.

6. Use of XR, VR, and AI in Simulation

Challenge: High cost and uncertain evidence base.

While AI and XR offer innovative solutions, access and evidence remain limited. Cost, infrastructure requirements, and single-user limitations were noted as key barriers.

> *"I like the idea that we can have those challenging patient conversations done virtually…[but] until they move to a higher level where we can have multi users in a room with Avatars then I'm not convinced that's where we can take it at the moment." Candidate 5, HEI*

> *"This is incredibly helpful for students before they go into practise…This is something that you can role play on your own so no one ever sees you." Candidate 9, HEI*

Call to Action

- Invest in scalable, evidence-based XR/AI tools.
- Create a national evaluation toolkit for immersive technology.
- Encourage shared procurement across institutions to reduce costs.

7. Impact and Evaluation

Challenge: Anecdotal evidence dominates; robust evaluation is rare.

Although examples of impact were reported—such as improved emergency response times and revised clinical protocols—robust, systematic evaluations remain limited. Organisational-level impact data is lacking.

> *"…we run a massive blood loss guideline test every year and we managed to reduce the time from the blood getting to the patient 3.5 minutes down to less than 30 seconds."*
> *Candidate 16, NHS Trust*

> *"We used simulation to develop new guidelines for bradycardia in the community."*
> *Candidate 6, NHS Trust.*

Call to Action

- ASPiH should collaborate with commissioners and Royal Colleges to establish a five-year research strategy.
- Develop a national repository of simulation impact case studies.
- Provide tools and templates (e.g., Kirkpatrick model, ROI/ROE calculators) to support local evaluation.
- Create a national mentorship network to build cross-sector simulation research capacity.

Final Summary

This report presents key insights from the ASPiH National Simulation Survey conducted in 2024 across the UK and Ireland. The survey gathered and analysed data from 107 survey responses and five focus groups, offering a comparative view with the 2014 survey to assess progress, challenges, and opportunities in simulation-based education and practice.

Simulation is not consistently embedded in organisational strategy and often relies on individual leads. Continued underfunding and a lack of protected time for simulation activities persist. Faculty development has improved but remains inconsistent and unfunded. Human factors and systems testing are increasingly used but not uniformly understood. Interprofessional simulation faces logistical and authenticity challenges. XR, VR, and AI adoption is hindered by high costs and limited evidence. Evaluation of simulation impact is largely anecdotal and lacks systematic measurement.

To address these challenges, this report recommends the integration of simulation into organisational strategies and the alignment of these activities with regulatory bodies such as the NMC, GMC, and HCPC. This report recommends developing processes whereby incremental year on year funding is secured to support the ongoing development of simulation activities. Faculty development should be supported through modular, tiered pathways which are aligned with the ASPiH standards. Frameworks like SEIPS should be promoted to support human factors integration, and interprofessional scenarios should be co-designed with stakeholders and coordinated across sectors. Investment in scalable XR/AI tools and shared procurement strategies is encouraged, along with the creation of a national repository and tools for measuring return on investment and excellence.

The expected benefits of implementing the recommendation in this report include the strategic prioritisation and sustainable funding for simulation activities, standardised and accessible faculty development, enhanced interprofessional learning and immersive technology use, including a more robust approach to evaluating and reporting the impact that simulation activities can have in improving patient outcomes and enhancing the practice of healthcare teams in health and social care settings.