

Evaluation of GMC Welcome to UK Practice

Final report
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1 Executive Summary

1.1 Background

Welcome to UK Practice (WtUKP) is a free half-day workshop offered to doctors who gained their primary medical qualification overseas and are either working or considering working in the UK. The aim of WtUKP is to help newly registered doctors to better understand the ethical and professional standards expected of them when working in the UK. Newcastle University were commissioned as independent researchers to evaluate WtUKP.

1.2 Aims

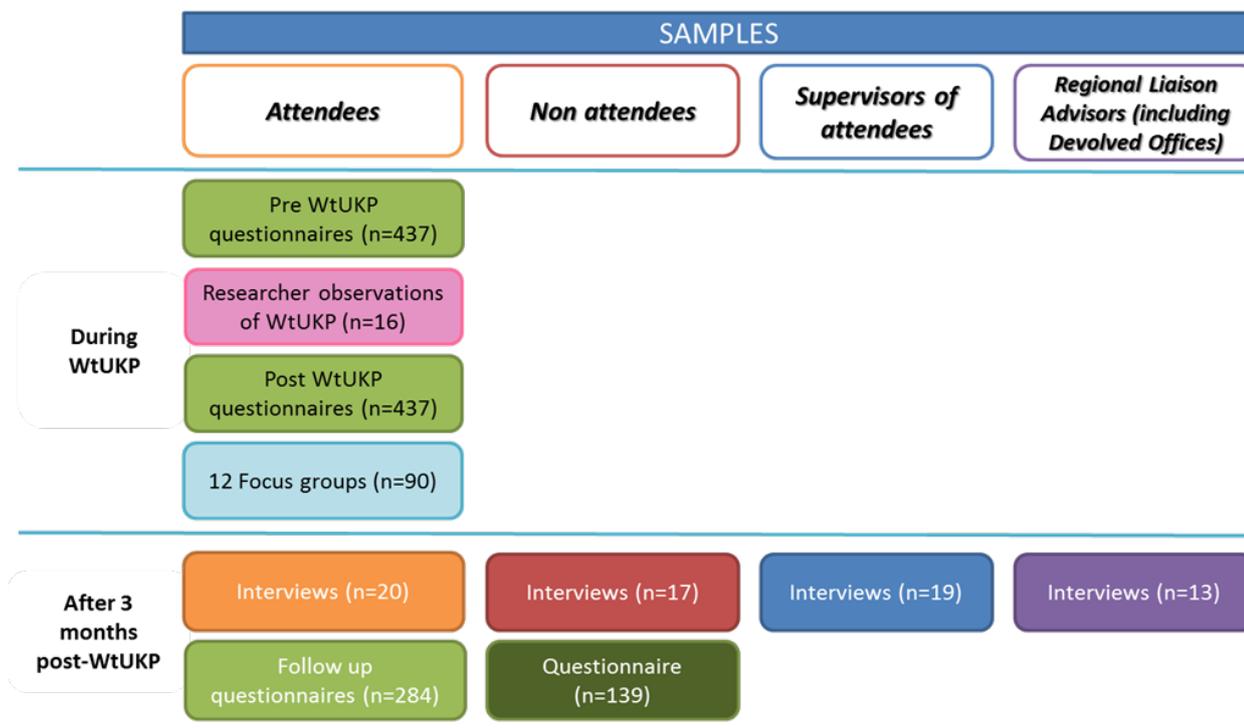
The broad aim was to identify the impact of WtUKP on supporting a successful transition to working in the UK for European Economic Area (EEA) and International Medical Graduates (IMGs). This included views on the content and delivery of WtUKP (both offline and online).

Research Aims:

1. To develop an evidence base on the short and long-term impact of WtUKP on participants and their practice.
2. To identify ways of improving the content and delivery of WtUKP offline and online.

1.3 Methods

The evaluation involved the collection of ten separate data sets using a mixed methods (qualitative and quantitative) prospective design, following up doctors over a three month period (see figure below). The study design enabled the triangulation of both methods and sources. The qualitative sampling approach used maximum variation purposively selecting participants for difference to gain a wide selection of views. Sampling continued until there was strong evidence of saturation of themes for both focus group and interview data. Attendee knowledge and understanding was assessed pre, post and follow up (three months) using questionnaires.



1.4 Findings

- *Short-term impact:* WtUKP is highly valued by overseas-qualified doctors and their supervisors. Attendees reported significantly improved awareness and understanding of the ethical issues covered in WtUKP, GMC guidance and UK practice in general. Scores on validated scales measuring doctors' patient centeredness and communication self-efficacy also improved. The evaluation demonstrated that WtUKP provides these doctors with the opportunity to meet other doctors in the same position, share learning from each other and gain additional support. Face-to-face delivery of the workshop was favoured by doctors, it being essential for interaction and providing the opportunity to ask questions.
- *Long-term impact:* Many of the short term improvements were sustained at the follow up stage after three months. However, decay was evident in some areas of the doctors reported understanding of UK practice as well their perceived ability to apply GMC guidance. This decay was just as evident for those in practice, suggesting that learning from WtUKP may not be being reinforced here. Yet despite some decay, improvement in scores compared to baseline was evident, particularly around applying GMC guidance. Almost two-thirds (62%) of doctors reported that they had made changes to their practice as a result of what they learned in WtUKP.
- *Improved perception of GMC:* Although there were mixed views on the GMC, overall doctors reported that WtUKP had improved their perceptions of the GMC, particularly valuing the positive engagement with the GMC staff delivering WtUKP.
- *Is WtUKP more/less effective for different groups of doctors?:* Doctors who had EEA or IMG status both benefited from WtUKP and illustrated the same improvements in knowledge about the GMC and understanding about UK practice. Alongside having similar awareness and understanding prior to WtUKP, those in practice did not demonstrate any greater improvement post WtUKP in the areas tested compared to those not yet in practice. This highlights that the content of WtUKP is not necessarily acquired during practice, and reinforcing the need for all overseas-qualified doctors to attend WtUKP.
- *The need for a positive learning environment in practice:* The evidence from this evaluation has highlighted a general lack of support for overseas doctors when they are in practice. The majority of supervisors were unaware of WtUKP and none of them knew that their supervisees had attended. Negative experiences interacting with colleagues and undermining behaviours (including bullying) were also reported. These doctors also highlighted a lack of confidence to ask questions, raise concerns, and challenge senior colleagues when required, which reflected a negative learning environment.
- *Increasing attendance to WtUKP:* The findings in this report suggest WtUKP should continue to be delivered locally, nationally and flexibly (including at weekends). It may also be appropriate to explore offering WtUKP to doctors when they attend the GMC offices for ID checks. Many study participants underlined the importance of ensuring all overseas doctors attend and stated that they would even support the workshops being made mandatory.
- *Need for a longer session and follow up:* There was unanimous support for expanding WtUKP both in content and length. All data sets highlighted that ideally WtUKP should be targeted at doctors before starting work and followed up once in practice; so that real issues encountered in practice can be shared, discussed and clarified. Further opportunity should be in place to reinforce what they have learnt e.g. use of log book following WtUKP and online tools.

Recommendations to the GMC have been made following these findings.

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2 Introduction

There is currently a severe shortage of healthcare professionals in the UK, leading to a high number of unfilled medical posts (GMC, 2017). The NHS relies heavily on overseas-qualified staff to support effective healthcare delivery (GMC, 2016; Lacobucci, 2016) and Trusts and Health Boards are currently increasing recruitment of overseas-qualified doctors.

Despite the NHS's dependence on overseas qualified doctors (over a third of the medical workforce), there seems to be a lack of recognition that this group of doctors may need support to adjust their practice when working in the UK as they are likely to have begun practise with varying levels of understanding and knowledge about practice within the NHS. Given the differences in healthcare practice, structure, language and communication (Morrow *et al.*, 2013), transitioning into a new culture and professional practice is challenging and requires being able to adjust to the different cultural and social norms, not just competencies and language (Dickson, 2015; Slowther *et al.*, 2012; Woolf 2016). Because most overseas doctors are expected to have passed rigorous examinations before starting work (e.g. Professional and Linguistic Assessments Board and International English Language Testing System test), these individual differences are often overlooked. Doctors arrive in the UK and organisations expect them to fill a rota gap immediately upon arrival (Kehoe, 2017).

As a result, there have been some major concerns about professional practice of doctors who qualified outside of the UK and related costs (Tiffin *et al.*, 2017). It was illustrated in the NCAS report that non-UK-qualified doctors have higher rates of referral for both assessment and for exclusion/suspension from work compared to UK qualified doctors (NCAS, 2011). Other research illustrates that non-UK qualified doctors were more likely to receive "high impact" decisions at each stage of the General Medical Council's fitness to practise process. The referral rates were disproportionately higher amongst non-white UK qualified doctors (Humphrey *et al.*, 2011). Black and minority ethnic (BME) graduates trained overseas were also substantially more likely to fail their Royal College of General Practitioners (RCGP) examinations than their UK colleagues (Esmail & Roberts, 2013). Male doctors are particularly more likely to receive a GMC sanction or warning (GMC, 2017). Tiffin *et al.* (2017) highlighted that individuals most at risk of fitness to practise censure are older male EEA graduates, the majority concerning communication issues.

Tackling the issues presented is ultimately important for safe and effective practice, but also staff wellbeing and ensuring a smooth transition for overseas doctors. Overseas doctors are often attracted to opportunities to work in the UK by better: pay, working conditions, education, career opportunities and quality of life (Kehoe, 2017). However, after a great deal of effort, time and often-financial cost, these aspirations are not always fulfilled. This has resulted in increasing numbers of overseas-qualified staff leaving the UK (GMC, 2016, Holcombe *et al.*, 1995; Kehoe, 2017).

Previous research has found that overseas doctors require support at three main stages: before coming to the UK, at the point at which they start work and ongoing support when they are in their post (Rothwell *et al.*, 2013; Kehoe *et al.*, 2016). Deaneries across the UK have been advised by the GMC that they need to provide induction programmes for their overseas doctors, however these vary in terms of length and quality (Kehoe, 2017). Inductions if offered are rarely adequate and there is a lack of ongoing support, which is essential to ensure staff retention and improved performance (Esmail & Roberts, 2013, Kehoe, 2017). Previous research has highlighted the complexity of supporting overseas-qualified doctors (Kehoe *et al.*, 2016). This research suggests that there are three components; individual, training and organisational, that need to work together and be considered when supporting the progression of overseas health professionals. It is suggested that progression is largely dependent on the employer, their approach to learning and the support system offered (Kehoe *et al.*, 2016). Hofstede (2011) suggests that importance lies at the individual level, particularly differences in aspects of culture. Countries are compared on four dimensions: power distance, individualism, masculinity and uncertainty avoidance.

Differences in cultures and jurisdictions will undoubtedly impact upon ethical decision making in health care (Slowther *et al.*, 2012); examples of such issues arising including consent, information sharing, end-of-life decisions (Chaturvedi *et al.*, 2009) and the role of family members (Mobeireek *et al.*, 2008). Without the necessary support, these individuals will be heavily influenced in their decision-making by the norms in their own country (Searight & Gafford, 2006); a lack of understanding and awareness of the standards set in the UK may

lead to severe consequences for both the doctor and the patient. The lack of relevant information about legal, ethical and professional standards/guidance prior to starting work is evident particularly for those not in a training post (Kehoe, 2017). The UK health system is also widely regarded as less hierarchical than many systems in many countries from which IMGs originate (Hall *et al.*, 2004). Personality and gender differences may also play a key factor in acculturation experience, particularly if religion is added into the equation (Phillimore, 2011). There is therefore a need for governing bodies to ensure there is an overarching level of support and induction for overseas-qualified doctors; this is why the GMC developed Welcome to UK Practice (WtUKP).

Developed in 2014, WtUKP is a free half-day workshop and online self-assessment tool to support doctors new to UK practice. It helps them to understand the ethical issues that will affect them and their patients on a day-to-day basis, to meet UK standards of practice, and increase awareness of professional practice in the UK. The half-day workshop aims to help newly registered doctors to better understand the ethical and professional standards expected of them when working in the UK. WtUKP offers an opportunity for doctors to go through the GMC professional standard in *Good Medical Practice* using scenarios. In particular, the half day discusses in more detail guidelines and professional standards related to confidentiality, liaising with the police and complying with the law, taking consent, dealing with mental capacity, dealing with duty of candour and dealing with issues related to communicable diseases. WtUKP includes a video of overseas doctors sharing their experience of their transition to the UK workplace. The half-day is interactive and offers the doctors opportunity to meet other doctors in a similar situation to themselves.

WtUKP represents a proactive intervention by the GMC, aiming to reduce the number of adverse incidents from doctors who gained the primary medical qualification (PMQ) overseas. Since 2013, over 6000 doctors have attended WtUKP workshops. However, the GMC want to increase attendance, with the aim of reaching 80% of overseas-qualified doctors by the end of 2020. The GMC recognises that this is an ambitious target, particularly as there are high dropout rates of doctors who sign up to attend WtUKP workshops.

This research project aims to evaluate the impact of WtUKP and support increased participation of overseas-qualified doctors. To date, the GMC have collected self-reported feedback from attendees and observers, mainly addressing satisfaction and learning of the participants (Kirkpatrick, 1996). Policy makers and researchers are now concerned with understanding how to design interventions that maximise the impact. Traditionally, the focus of evaluation has been outcome-focused, with a move towards impact evaluation more recently (Greenhalgh *et al.*, 2015). Evaluation also requires understanding processes; how the benefits are generated and how impact may differ between individuals. The impact of educational interventions, like WtUKP, are complex and need to consider the intervention alongside contextual information about the targeted population and the context of practice. Process evaluation, along with exploration of short and long-term impact, is needed to inform the future delivery of WtUKP.

This report provides an overview of the methods and findings from an eight-month period of data collection evaluating WtUKP. Findings from a synthesis of all data is provided: observational, questionnaire, focus groups and interviews. Recommendations have been provided to the GMC for consideration.

2.1 Aims and objectives

The broad aim is to identify evidence on the impact of WtUKP on supporting a successful transition to working in the UK for European Economic Area (EEA) and International Medical Graduates (IMGs). This included views on the content and delivery of WtUKP (both offline and online).

Research Aims:

1. To develop an evidence base on the short and long-term impact of WtUKP on participants and their practice.
2. To identify ways of improving the content and delivery of WtUKP offline and online.

Research Questions:

1. How well is WtUKP being delivered?
2. How could it be improved? (Process; including outputs and reaction)
3. What difference has WtUKP made and how? (Impact; including learning and behaviour)
4. Is WtUKP more, or less effective for different groups of doctors and why?

3 Methods

The evaluation involved the collection of ten separate data sets using a mixed method (qualitative and quantitative) prospective design. The evaluation design involved collecting data at three points: pre, post, and three months following WtUKP; see figure 1 in findings. The study design enabled the triangulation of both methods and sources. Attendee knowledge and understanding was assessed using questionnaires. Qualitative data helped add further explanation and explore the impact of WtUKP.

This research drew on both post-positivist (quantitative data) and constructivist (qualitative data) research perspectives. A post-positivist perspective assumes that the social world can be measured but accepts some degree of uncertainty due to the limitations of the method (i.e. sample of a population) and the imperfections of a human researcher measuring a social rather than natural phenomena. To support this approach, the questionnaire drew on items from validated questionnaires to improve the reliability and validity of findings and drew on hypotheses to target the statistical analysis, rather than analysing every possible permutation.

The qualitative methods were used to provide further understanding and explanation, complementing the questionnaire data. The knowledge created from the qualitative methods drew on a constructivist research perspective, recognising that the population was a subset of the larger population, hence we attempted to purposively select respondents using a maximum variation approach to gain a wider perspective (more generalisable). This perspective identifies there are multiple views of reality and experiences are subjective. New knowledge is co-created from the data provided by the participants and interpreted by the researcher to create understandings by synthesising all the data. Bias is not a concern with this approach, recognising the human researcher is part of the research process and cannot be removed. Sampling continued until there was strong evidence of saturation of themes for both focus group and interview data.

3.1 Quantitative data collection

An entire cohort of doctors participating in WtUKP workshops between January and April 2018 were recruited (The GMC were expecting between 300-400 doctors). The main purpose of collecting data from these doctors was to explore the effectiveness of WtUKP; exploring learning outcomes and transition over a three-month period.

3.1.1 Pre and post WtUKP questionnaires

Pre and post WtUKP questionnaires were developed containing measures that were relevant to learning during WtUKP. The majority had been used in previous research with doctors who qualified overseas (Kehoe, 2017). Questionnaires assessed knowledge of practice in the UK and GMC guidance before and after WtUKP, as well as doctors' intention to change their practice. Two validated scales were included; the Patient-Practitioner Orientation Scale (PPOS), (Krupat *et al.*, 2000) and the Communication Self-efficacy scale (Parle *et al.*, 1997; Gulbrundsen *et al.*, 2013) (see Appendices 1 and 2 for full questionnaires). These were specifically chosen as they have been successfully used in previous evaluation research on interventions for overseas doctors. The scales also focus on areas that would give us a better understanding of the impact of WtUKP.

PPOS is an 18-item questionnaire that differentiates between patient-centred versus doctor-centred orientation, measuring attitudes along two dimensions: sharing and caring. The 'sharing' subscale consists of 9 items, which reflects the extent to which the participant believes that the patient should receive information and be involved in the decision-making process. The other nine items, the 'caring' subscale, assess whether the patients' expectations, lifestyle and feelings are taken into consideration during a consultation. Higher scores indicate a

more patient-centred orientation. The purpose of including this questionnaire is to explore whether WtUKP impacted upon participants' attitudes and understanding towards UK practice, an increase in scores thus reflecting practice more in line with UK ideals. An increase in scores have also been linked to positive outcomes such as patient satisfaction (Krupat *et al.*, 2000). The Communication Self-efficacy scale is a 9-item questionnaire that looks at the role that self-efficacy plays in abilities to assess patient concerns. This questionnaire was chosen as it assesses both learning and self-efficacy, an increase in scores being associated with positive changes in a doctor's practice (Gulbradsen *et al.*, 2013).. The questionnaires were also used to explore what doctors expected from WtUKP, what they found useful, and how the workshops could be improved.

Vignettes were developed to help assess what the attendees had learnt during the WtUKP workshops (see Appendix 3). The four vignettes were adapted from *Good Medical Practice* examples available on the GMC website (with input from the GMC, overseas doctors and UK-qualified doctors). The vignettes were specifically chosen to cover the same areas of *Good Medical Practice* discussed in WtUKP. These were given pre and post WtUKP to assess attendee knowledge of how to respond to the specific scenarios. An answer sheet on the vignettes was provided to attendees after the workshop, explicitly referring to GMC guidance about each correct answer (see Appendix 3).

Questionnaires were handed out at the start of the WtUKP workshops, containing an information sheet (see Appendix 4). Attendees were assured that Newcastle University were collecting the data as a separate organisation from the GMC. Consent to participate in all aspects of the evaluation (i.e. questionnaire, interview, permission for performance data from supervisors, etc.) was sought during the first contact. Individuals were asked to provide the last four digits of their longer GMC unique ID numbers to enable the researchers to anonymously link their pre, post and follow up questionnaire data.

3.1.2 *Three-month follow up questionnaire*

The follow-up questionnaire included the same validated questionnaires (PPOS and communication self-efficacy) and measures relating to practice in the NHS and understanding of GMC guidance (to allow analysis to take place over the three time periods). Additional questions were included to explore whether the doctor had utilised what they had learnt during the workshop, how WtUKP will help in the future, additional support or training required, and their perceptions of the GMC (see Appendix 5 for full questionnaire).

The follow-up questionnaire was sent out via email three months after the doctors had attended a WtUKP workshop. At the end of the questionnaire doctors were asked if they would be willing to provide contact details of their educational supervisor so a researcher could arrange an interview with them.

Data collected from a previous research study (Kehoe, 2017) suggested that study response rates would be adequately powered to show a significant difference in the questionnaire outcomes with a power of 0.8 to detect an inter-group difference at the 0.05 level of statistical significance (with regard to PPOS and the communication self-efficacy scale).

3.1.3 *Non-attendees' questionnaire*

Doctors who had registered but did not attend a WtUKP workshop were invited to complete a similar online questionnaire (non-attendees). The questionnaire included the same key components of the questionnaire that were administered to the attendee sample (NHS and GMC understanding, PPOS, communication self-efficacy, demographics, use of online tool, perception of the GMC etc; see Appendix 6 for full questionnaire). Additional items were added to explore reasons why the doctor was unable to attend, possible solutions for future attendance and additional support required.

This sample was recruited via the GMC, who had collected data exploring those who had signed up to WtUKP during the evaluation period but were unable to attend. An email seeking participation and an information sheet were then sent to these individuals (see Appendix 7).

3.2 Qualitative data collection

3.2.1 *Researcher observations of WtUKP workshops*

The 'real time' nature of the evaluation meant that researcher observations were utilised as a further source of triangulation. Observations provide a good opportunity to feed in valuable data about the implementation of WtUKP. Observing the workshops helped the researchers to understand more about how they worked.

Six researchers systematically observed twelve WtUKP workshops, using detailed observation sheets developed by Newcastle University (see Appendix 8). This ensured consistency in recording the data. The sheets focussed on delivery, content, interactions during WtUKP, and commonality across the number of sites. Contextual factors were important. Other detail such as expected number of attendees and actual number of attendees were identified to enable the researchers to calculate the attrition rates.

3.2.2 *Focus groups*

Focus groups were used to capture the perspectives of the attendee's immediately following WtUKP. Attendees were invited to take part in a focus group when they signed up to attend. Participants were sampled to ensure a mix of gender, specialty, whether they were in practice and place of primary medical qualification. Newcastle researchers emailed the chosen sample to invite participation in a focus group. The researchers aimed to recruit up to ten doctors for each focus group.

At the start of the focus group, participants were directed to the information sheet that was given to them prior to the workshop and a consent form to sign. A topic guide was used to facilitate the discussion (see Appendix 9), which covered what the doctors had learnt (relating to specific aspects of *Good Medical Practice* covered during WtUKP), how they could apply learning in practice, and how WtUKP could be developed in the future. The focus groups took between 50 and 90 minutes.

3.2.3 *Interviews with doctors who attended WtUKP*

A sample of the doctors who attended WtUKP were interviewed after completing the three-month follow up questionnaire (aiming for approximately 20 to ensure data saturation). Doctors were purposively selected from questionnaire demographics, using maximum variation to ensure representation of a number of key variables i.e. EEA, IMG, gender and length of time in the UK etc. The main purpose of these interviews was to explore the perceived effectiveness of WtUKP and to gather data on learning outcomes and transition over a three-month period. Therefore, interviews only took place with those doctors that were in practice in the UK. Interviews took place over the telephone and lasted between 20-60 minutes (see Appendix 10 for topic guide). Verbal consent was obtained prior to recording.

3.2.4 *Interviews with supervisors of WtUKP attendees*

Those doctors who had attended WtUKP and had taken part in an interview were asked if we could also recruit their supervisor to take part in an interview. There were several recruitment challenges that resulted in a limited sample through this method (n= 4). Additional supervisors were therefore recruited via the online follow-up attendee questionnaire sample and via individual Trusts through purposive sampling. Only those who were currently supervising or had previously supervised an overseas doctor that attended WtUKP were interviewed. Interviews lasted between 20 and 60 minutes. An information sheet was sent to participants (see Appendix 11) and verbal consent was obtained prior to conducting the interview.

Supervisor feedback was crucial in ensuring triangulation of perceptions concerning attendee doctors learning outcomes and transition to UK practise. From our experience, this element added an important perspective to the evaluation (see Appendix 12 for topic guide). Gaining the views from supervisors was especially important as much of the other data sources collected were self-reported.

3.2.5 *Interviews with non-attende group of overseas-qualified doctors*

Following completion of the online questionnaire, a sample of the doctors who did not attend WtUKP were also asked if they would take part in an interview (aiming for a sample of 20). Only those who indicated they were currently in practice were contacted to take part in an interview. Again, maximum variation was used to purposively select doctors on a range of relevant but different variables (length of time practising in UK, gender etc.).

This sample were recruited primarily to understand why they were unable to attend WtUKP despite registering and explore if there were any barriers that could be addressed in the future (see Appendix 13 for interview guide). General transition into UK practice and perceptions of the GMC were also explored. Following verbal consent, interviews lasted between 20 and 60 minutes.

3.2.6 *Interviews with Regional Liaison Advisors (RLAs)*

All fifteen RLAs were invited via email to take part in a telephone interview which lasted between 30 – 80 minutes (following verbal consent). These RLAs delivered WtUKP both nationally and locally (including the devolved GMC offices). Participants were sent an information sheet via the GMC (see Appendix 14). Interviews explored development and implementation of the WtUKP workshops (see Appendix 15 for topic guide). These interviews also involved discussion of the interim findings to seek participant feedback and validation.

3.3 Ethics

Ethical approval was obtained from Newcastle University School of Medical Education subcommittee. Participants were offered a £10 gift voucher as a thank you for taking part in a focus group or interview, and on completion of questionnaires.

3.4 Analysis

3.4.1 *Questionnaire data*

After data had been cleaned; pre, post and follow up data was analysed using IBM SPSS statistics version 4. Data was reverse scored where necessary. The PPOS scores have been re-scored in the write up to reflect the same direction of scoring as the majority of other questionnaire items, where 6 or 7=high (e.g. originally 1=high on PPOS, but now 6=high).

Descriptive analyses were run and means and standard deviations (SD) are presented throughout the report. Reliability analyses were conducted on full data sets where appropriate. Depending on the comparison, relevant statistical analyses were conducted, including paired and independent t-tests, repeated measures ANOVA, and non-parametric tests where appropriate. Descriptive means were calculated from all responses to that question, whilst statistical tests were only ran on full data sets i.e. only the respondents who answered all the relevant questions (hence sample sizes may differ depending on the analysis). Mean scores may therefore vary slightly depending on the data being presented. Furthermore, post-hoc analyses were not run on all datasets, only where it was appropriate to do so following initial analyses across all datasets (i.e. a significant ANOVA result across all three time points; pre, post and follow up, led to follow up tests looking for differences between specific time points).

Where statistically significant differences were found, effect size was also calculated (Cohens D). This was particularly important where mean differences did not appear to be substantial, yet a statistical difference was found. Whilst these are not reported in the findings, all effect sizes ranged between 0.2 and 1 (the majority indicating a relatively large effect size).

Datasets were chosen for comparison according to hypothetical rationales, looking between specific data sets and across different time points. The primary aim of this evaluation was to evaluate the effectiveness of WtUKP by comparing them before and after attending. Although some comparisons can be made to the non-attende group and differences explored, these doctors were not matched in any way and came from a very diverse group. The

purpose of the non-attendee data was primarily to explore reasons they were unable to attend and what perceived effect this may have had on their practice.

An aggregate score for the four items on 'understanding of GMC guidance' (items 14-17 on questionnaire; see Appendices) was calculated and is sometimes used within the analysis rather than reporting on each piece of guidance individually. Reliability analyses indicated that internal consistency reliability was satisfactory (Cronbach's alpha: pre = .88, post = .89, follow-up = .80, non-attendees = .86).

3.4.2 Qualitative data

3.4.2.1 Free text analysis

Questionnaire free text comments were analysed using a qualitative thematic approach (Braun & Clarke, 2006). This involved reading of the comments made in the free text questions within the questionnaire and using the six steps of thematic analysis as described by Braun and Clarke: 1) familiarisation with the data, 2) coding of the data, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, 6) writing up.

3.4.2.2 Observation and focus group data analysis

Focus groups were transcribed verbatim and all transcripts were distributed between four researchers for analysis. Researcher observations were also analysed at this point. Observation and focus group data were analysed using the thematic approach described above (Braun and Clarke, 2006).

Key themes across all data were identified and developed during the analysis period. The themes were further reviewed and discussed during the drafting of the findings section for the interim report. This was to ensure the themes accurately reflected the meaning of the data. Data saturation was reached after ten focus group and the final two focus groups were used to check the themes.

3.4.2.3 Interview data analysis

The themes identified from the observation and focus groups were then used to develop a framework for all further qualitative data analysis. Following transcription by NData UK, interview transcripts were coded using this initial framework. Our previous research also fed into the development of the framework and understanding of the data (Kehoe *et al.*, 2016).

The framework approach (Ritchie & Spencer, 2002) to analysis was adopted. The stages of analysis involved:

- *Familiarisation* - gaining an overall view of the data that had been collected. This involved reading the transcript data and noting the range, depth and diversity in the data collected. Meetings between five researchers engaged in the same process enabled discussion of the concepts and themes that emerged from the data.
- *Identifying a thematic framework* - identifying the key issues, concepts or themes by which the data could be examined and sorted. The construction of the framework drew upon:
 - *a priori issues* - those issues that guided the study aims and were developed into the focus group/interview schedule;
 - *emergent issues* - those issues that were raised by the respondents
 - *analytic issues* - those themes that emerged from patterns and re-occurrences in the data
- *Indexing* – applying the framework to the data. This involved re-reading the transcripts and marking sections of text, which relate to themes or sub-themes in the thematic framework.
- *Charting* – collecting all the selected sections under a theme and viewing the data as a whole for each theme. The researchers read the quotes and looked for similarities and differences in the data as well as sub-themes that sat below a theme.
- *Mapping and interpretation* - bringing the key themes within the data set together and pulling together the findings of the analysis to address the aims and objectives.

Researchers coded the transcripts independently and then discussed what had emerged from the data within the transcripts (familiarisation). The researchers then analysed the data to answer the research questions (developing thematic framework). Each of the researchers coded and analysed a sub section of the data sample. Data saturation was reached within each sample.

The researchers discussed their coding again and started to draw together the themes identified within the transcripts. Whilst there was a great deal of overlap within and across the data sets, there were some differences identified between the data sources. Discussions and further analysis led to further agreement on themes.

The researchers then discussed the analysis and how best to capture the evidence from the qualitative data to inform the research questions. Following discussion, researchers agreed that they would focus on reporting the data in relation to short-term impacts, long-term outcomes, content, and perception of the GMC etc. This formed the final analytic framework, which enabled the findings from each data set to be input into the framework matrix (indexing).

3.4.3 Synthesis of all data collected during the study

Although each data sets and from the various participant groups were analysed separately, full analysis took place across all data sources. Once themes had been identified following triangulation of the data, further discussions took place between the researchers to enable the synthesis of data and development of the most relevant explanation to answer the research questions.

4 Findings

Key findings and implications relating to the research aims will be presented in this section. An overview of the data collection sources and samples are illustrated in Figure 1.

The evaluation involved the collection of multiple data sets using a mixed methods prospective design. This enabled the triangulation of both methods and sources. Data saturation was achieved for focus groups and interviews.

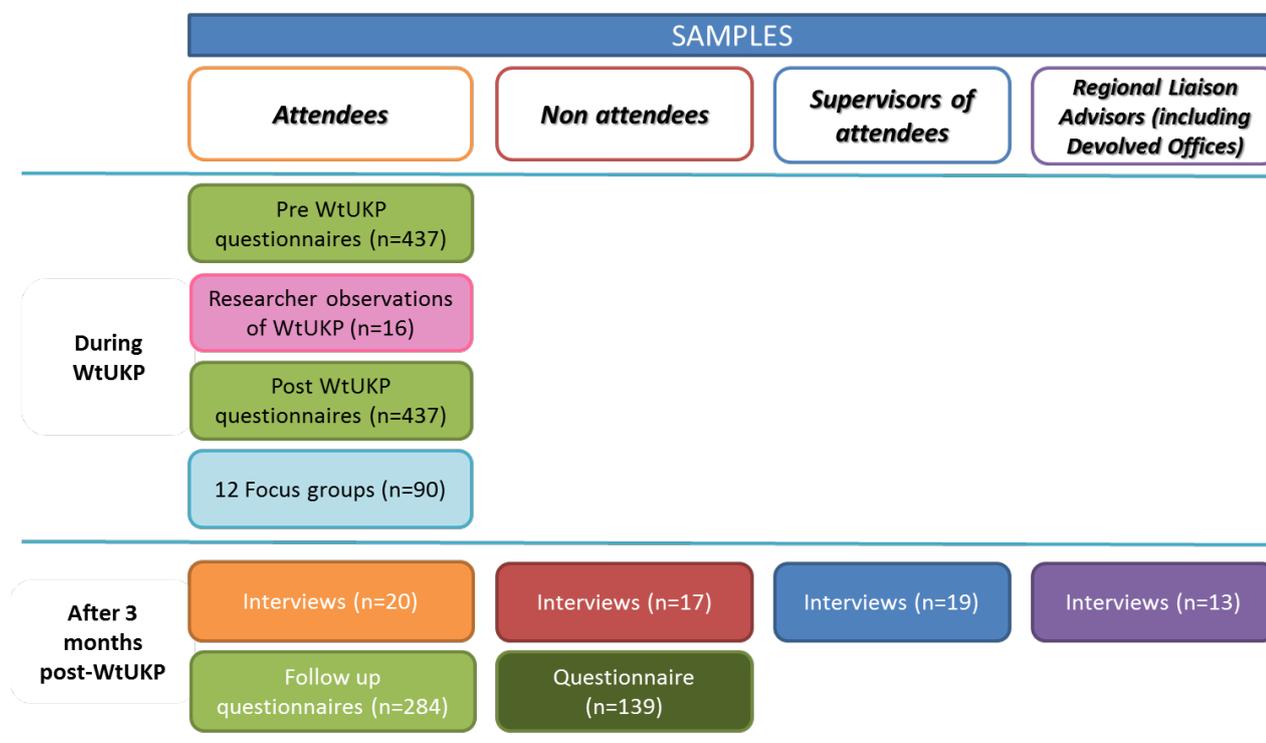


Figure 1. Diagram to illustrate data collection during 8-month study period

High levels of agreement were identified across the data sets and a range of participants. The findings presented in this report are derived from the following data sets:

- **Observation**
- **Focus groups**
- **Questionnaire data**
 - Pre-questionnaire
 - Post questionnaire
 - Follow up questionnaire
 - Non-attendees questionnaire
- **Interviews with attendees**
- **Interviews with non-attendees**
- **Interviews with supervisors**
- **Interviews with RLAs**

4.1 Data set and participant group profiles

Observations

Eighteen workshops were included in this evaluation between January and April 2018. The included workshops were held in the following sites: London, Manchester, Cambridge, Edinburgh, Bangor and Wrexham.

Focus groups

Six researchers facilitated 12 focus groups following the WtUKP workshops in the following cities: London, Manchester, London and Edinburgh. In total 90 doctors took part in a focus group. Data saturation was achieved after 10 focus groups and two further groups were conducted to 'member check' the identified themes.

Questionnaire data

Most doctors who had attended a WtUKP workshop agreed to participate in the questionnaire (95.7% response rate). Four hundred and thirty-seven pre and post questionnaires were collected from 18 WtUKP workshops. See table 1 for a breakdown of the demographics of doctors who attended WtUKP and who had completed the attendee questionnaire. The table also provides data on doctors who signed up, but were unable to attend WtUKP, and who had completed a non-attendee questionnaire. The percentages within the table are based on doctors that responded to the specific questions relating to demographics (missing data has not been reported). It is clear from this table that attendees and non-attendees differed; the non-attendee sample consisted of more males, more IMGs, more were in practice, were slightly older, more were married with children, and the majority were Muslim. These demographics suggest possible reasons why this group of doctors had more difficulty attending WtUKP (discussed in more detail later). The sample of practising doctors in both questionnaires included a range of roles, specialties and time/experience in practice.

Table 1. The demographic profile for attendee and non-attendee doctors (questionnaire data).

Attendees n= 437		Non-attendees n= 139	
Male 39%	Female 49%	Male 54%	Female 43%
IMG 66%	EU 24%	IMG 85%	EU 15%
47% in practice	37% not in practice	74% in practice	26% not in practice
90% 0-6 months in practice		60% 0-6 months in practice	
Age: 25-34 (59%) 35-44 (22%) 44> (5%)		Age: 25-34 (53%) 35-44 (28%) 44> (15%)	
*Ethnicity: Asian 38% White 22%		*Ethnicity: Asian 51% White 24%	
*Religion: Muslim 25% Christian 30%		*Religion: Muslim 41% Christian 31%	
*Marital status: 46% married		*Marital status: 70% married	
*Dependents: 30%		*Dependents: 57%	

Missing percentages indicate no answer.

*Missing percentages indicate other variables or missing data.

Interviews with attendees

Twenty overseas doctors who had attended WtUKP took part in an interview three months after attending a WtUKP workshop. Demographics supported maximum variation; the sample included IMGs and EEA doctors, both males (n=4) and females (n=16), a range of ages, a range of levels from foundation to specialty training, a range of specialties including paediatrics, surgery, emergency medicine, obstetrics and gynaecology, anaesthetics and a range of practice locations throughout the UK. All doctors were in practice at the time of the interviews.

Interviews with non-attendees

Seventeen doctors who were unable to attend a WtUKP workshop were also interviewed. The sample were selected to achieve maximum variation (an attempt to be more generalizable) and included: male (n=11) and females (n=6), IMG and EEA doctors. It also included a mix of levels and experience and doctors from a range of specialties including surgery, psychiatry and general medicine.

Interviews with supervisors

Nineteen interviews took place with supervisors. Eight of the participants were IMGs themselves. Participants consisted of both males (n=8) and females (n=11) and were from a range of specialties, including paediatrics, psychiatry, obstetrics and gynaecology, emergency medicine, intensive care medicine and surgery.

Interviews with RLAs/DOLAs

Thirteen out of the 15 Regional Liaison Advisers (RLAs)/Devolved Office Liaison Advisers (DOLAs) took part in an interview. The length of time working as an RLA/DOLA ranged from one to seven years. Ten females and three males were interviewed, including managers and representatives from all four Nations in the UK.

Synthesis of findings

The data presented below is a synthesis of findings by theme, not by method. This approach strengthens the messages and avoids repetition. We have sought to be transparent when presenting findings, ensuring it is clear what data sources informed each of the identified themes.

4.2 The need for Welcome to UK Practice

All participants highlighted that there was a need for WtUKP. Participants were unanimous on the view that WtUKP was beneficial for overseas doctors entering the UK healthcare system. This finding emerged from both the qualitative and quantitative data.

Eighty six percent of doctors who had attended the workshop reported WtUKP was good or very good, while 87% reported that they would recommend WtUKP to another doctor who was new to the UK.

“Definitely because when you come from another country and you’re pretty alone and you go to this event and everyone is new, and they are also figuring their way around. So, I would definitely recommend it”.
(Attendee 20_female)

Many attendees commented that the WtUKP workshop was useful in helping them make the transition into UK healthcare practice. Several doctors reported that the workshop had helped them know what to expect when coming to practice as a doctor in the UK. WtUKP highlighted important issues related to communication with patients, asking for help, and raising concerns. Attendees also reported it increased their confidence.

“It was a helpful presentation and we were exposed to different scenarios, which we might encounter during our daily working environment and I haven’t worked in the UK yet, but it will be a great idea to go to all those things before you actually start practicing in the UK. (Attendee 5_male)

The workshop also facilitated reflection on how UK practice differed from practice in the doctors’ own countries. Attendees subsequently felt more confident practising in the UK following awareness of these differences.

“It’s helped me in a way to adjust to a new environment, you know, the culture in Pakistan is slightly different from the culture in the UK. So, it’s actually helped me understand how the GMC works, what is the role of the GMC, and how patients and the Medical staff are different in both countries and it actually helped me adjust to the UK environment”. (Attendee 2_male)

All of the RLAs interviewed were very positive about the WtUKP workshops. Many RLAs stated that delivering WtUKP was the part of their job they enjoyed the most. It was also the workshop, which generated the most positive feedback. RLAs also talked very positively about the overseas-qualified doctors who attended.

“I’ll tell you this, of all the teaching sessions I do across a whole range of doctors this is my favourite by far. The positive effect it has on the doctors and the number of times I’ve been dragged onto the corridor outside and been forced to have my photograph taken with all the doctors with the GMC logo, but it’s really heart-warming honestly, I absolutely love doing the sessions”. (RLA 3_male)

During focus groups and interviews, doctors were unanimous about the benefits of attending the WtUKP workshop. It covered important ethical issues and different approaches to practice and working with patients and colleagues. They felt that the workshops had set them on the right path to good medical practice in the UK.

“I think the course is really good to make you aware of where you can find the information and how to approach situations where you don’t know off the top of your head”. (Focus Group London, L/24)

4.2.1 Comparison of those in practice with those not in practice before WtUKP

Baseline data collected pre WtUKP highlighted that there was a need to deliver WtUKP content to all doctors, whether in practice or not. Table 2 illustrates that prior to WtUKP, the doctors in practice (46.5%), who had an average of five months experience of the NHS scored no higher than the doctors with no experience of UK practice on most of the measures. Attendees in practice actually scored significantly lower on their perceived ‘ability to deal with cultural differences’ and ‘understanding of the structure and hierarchy in the NHS’. This is an interesting finding, as we would have expected that those in practice would have slightly more understanding in most areas and have started to adapt their practise to fit with those in the UK.

Most of the scores illustrate moderate perceived understanding across most areas for both groups of doctors. The data suggests that both groups were getting an average of 3 out of the 4 knowledge tests correct. Interestingly, both groups reported that they had the highest awareness and understanding prior to WtUKP in similar areas. These areas included *adjusting practice, multidisciplinary team working, asking others for help, and being open and honest with patients*. The groups also both reported their lowest scores in *understanding the structure and hierarchy of the NHS* and *being aware of how to challenge poor behaviour of senior colleagues*. Evidently, doctors perceived that they had learnt no more about managing challenging areas having been in practice. In fact, those in practice scored slightly lower in these areas. Ultimately, this finding could suggest that we cannot assume doctors will learn about the NHS and GMC guidance, specifically WtUKP content just through the being in practice. However, it is important to note that doctors who have not yet been in practice may hold an unrealistic perspective about what they know (i.e. you don’t know what you don’t know), therefore doctors may have reported higher perceptions of awareness and understanding.

Table 2. Table illustrating mean questionnaire scores for attendees PRE WtUKP, comparing those in practice; who had been practicing an average of 5 months (n=203), and those not in practice (n=162); independent sample t-tests presented

Measures/Scale	Attendees in practice pre WtUKP		Attendees not in practice pre WtUKP		T-test		
	Mean	SD	Mean	SD	t	df	p
Communication self-efficacy (5=high)	3.88	.636	3.88	.606	.019	354	.985
PPOS global: Patient Centeredness (6=high)	3.34	.531	3.40	.523	1.021	335	.308
- PPOS Shared decision making (6=high)	3.13	.711	3.24	.670	1.520	352	.129
- PPOS Care and compassion (6=high)	3.57	.529	3.56	.492	-.060	339	.952
Knowledge about GMC guidance (vignettes) (4=high)	3.19	.837	3.30	.794	-1.200	328	.231
Awareness of GMC guidance; combined scale (7=high)	5.33	1.158	5.41	.97	-.612	301	.541
I am aware I will need to adjust my practice to fit the UK medical system (7=high)	6.33	.900	6.43	.803	-1.110	362	.268
I am aware of the challenges I may face practising medicine in the UK (7=high)	5.93	1.024	5.79	1.225	1.149	308.6	.251
I understand the role of the GMC (7=high)	5.83	1.071	5.84	1.018	-.058	357	.954
I feel able to deal with cultural differences that I may face in practice (7=high)	4.17	1.615	4.55	1.487	2.307	358	.022
I understand the structure and hierarchy of the NHS (7=high)	2.60	1.661	2.97	1.596	2.112	360	.035
I am comfortable working as part of a multidisciplinary team i.e. working in a team with other doctors, nurses, health care assistants etc. (7=high)	6.55	.740	6.62	.749	-.864	362	.388
I am comfortable asking others for help if needed (7=high)	6.45	.888	6.58	.658	-1.487	360	.138
I understand how to communicate with patients' relatives (7=high)	5.97	.956	5.94	.875	.269	361	.788
I am aware of how to challenge poor behaviour of a senior colleague (7=high)	2.78	1.623	2.80	1.597	1.278	360	.202
I am aware of the need to be open and honest with patients following an error or mistake (7=high)	6.42	.757	6.42	.898	-.004	361	.997
I feel the GMC are supportive of doctors (7=high)	5.31	1.454	5.59	1.305	-1.961	359	.053

Note: All comparisons checked for equality of variances using Levene's test. All had equal variances except Q3 and Q12, in which case adjustments were made using SPSS for unequal variances.

4.3 Short-term impact (immediately following WtUKP)

4.3.1 Improved knowledge of the ethical issues covered in WtUKP

Attendees were asked to read four scenarios (vignettes) that assessed their understanding of the broad ethical issues covered within WtUKP. The four scenarios focussed on consent (specifically a scenario addressing mental capacity), duty of candour (admitting mistakes to patients), raising concerns (specifically a scenario about a colleague), and confidentiality (specifically a scenario relating to communicable diseases. Attendees' knowledge was assessed through a multiple-choice question asking: 'what should the doctor do next?' (see Appendix 3 for full vignettes).

Overall, there was evidence that the attendees' knowledge across these ethical issues had improved as a result of WtUKP. Following the workshop, there was a significant increase in the proportion of trainees giving a correct response to three out of four of the knowledge tests (table 3). This included the vignettes assessing consent, duty of candour and raising concerns.

Table 3. Table illustrating attendee scores on knowledge test pre and post WtUKP (McNemar test on full data sets only)

Vignette (knowledge test)	Pre (% correct answer)	Post (% correct answer)	Sig (McNemar test)
1 Consent (mental capacity)	85.3	89.4	.009
2 Duty of candour (admitting mistakes and communicating to patient)	85.1	94.2	<.001
3 Confidentiality (HIV)	79.6	76.6	.314
4 Raising concerns (about colleagues)	73.9	81.6	.001

Attendee doctors highlighted the importance of working through similar scenarios during WtUKP and the benefits they perceived. They reported that the video scenarios had brought the issues to life and put the learning points into context. They particularly enjoyed the discussion in between part one and part two of each scenario.

"...the scenarios, the videos...they were in two parts, the first part you show a scenario, after there's a group discussion within the table and then you come up with various different ideas, you discuss amongst yourself and then what is the best practice, which is told [to us]. I think that's a very good idea". (Focus Group London, L/3)

The questionnaire data supports this, suggesting that the WtUKP content, particularly working through scenarios, had a positive impact on understanding of ethical issues. It is hoped doctors will go on to apply this acquired knowledge into practice.

However, there was no improvement in the proportion of trainees responding correctly to the scenario on HIV (confidentiality) in Vignette 3 (there was actually a slight decrease). This lack of improvement may reflect the fact that communicable diseases are a complex area and this topic was rarely covered in the same detail across all the WtUKP workshops, if at all. It is important to acknowledge here that under normal circumstances a video on serious communicable diseases would have been shown during WtUKP sessions, however because of the limited time available, largely due to this evaluation, it was not always possible and therefore often referred to as an additional consideration to another confidentiality scenario. Observations and the discussion in focus groups immediately following WtUKP workshops highlighted the confusion around the specific issue of communicable diseases. For example, it was indicated in the workshops that the scenario on HIV could be a public interest issue, and some attendees understood this to mean that confidentiality could be broken. Since the evaluation period this specific video has been reinstated as a standard part of the session, with these findings indicating the importance of covering such scenarios in greater detail.

4.3.2 Better understanding of GMC guidance

Doctors who attended WtUKP reported a significant increase in their understanding of the role of the GMC (see table 4). Attendee interviews also highlighted that following the WtUKP workshop, doctors' knowledge of the GMC had increased, and they understood the role of the GMC in more depth.

"I came out slightly more assured about the role of the GMC, so I think that was a very useful thing..."
(Attendee 9_male)

Table 4. Table illustrating attendee and non-attendee perceived understanding about the role of the GMC (whole sample)

Measures/Scale (7=high)	Pre-WtUKP (n=384)		Post-WtUKP (n=392)		T-tests		
	Mean	SD	Mean	SD	t	df	p
I understand the role of the GMC	5.83	1.051	6.46	.661	-11.53	361	<.001

Questionnaire data further suggested that non-attendees felt less aware of the role of the GMC compared to attendees both pre- and post-WtUKP. Again, this is interesting since 74% of the non-attendees were in practice. However, overall, the scores were relatively high for all groups. This may reflect the fact that the majority of all doctors need to register with the GMC and undergo the same processes, regardless of whether they attend WtUKP or not. Therefore, they may feel they understand the role of the GMC as a regulator. In addition, the majority of attendees were IMGs (85%) who would likely have had to sit the PLAB examination and studied specific aspects of GMC guidance to ensure they passed.

Only 77% of attendees were actually aware of GMC guidance prior to WtUKP. As would be expected, this went up to 100% after attending the workshop. Post WtUKP doctors reported more willingness to consult with GMC guidance, as well as a better understanding of how to apply it. The data indicated a significant increase in perceived understanding of how to apply specific GMC guidance on consent, confidentiality and how to raise a patient safety concern (see table 5).¹

Attendees commented that if they had not used the guidance, they now knew where to look if required later. In addition, they also reported greater confidence to approach the GMC if they faced future difficulties in practice and the positive impact that this had on them.

"I haven't known anything about the duty of candour, how to escalate things and when to escalate things...I had all these handouts from the GMC about confidentiality, guidance in dealing with young patients, good medical practice and the most important one in my opinion was the consent because this was the most challenging part for me. I got to know that if I fell into any situation I could access these books, I could contact the GMC and seek their advice in any situation I could be. So I believe it was very helpful and really essential, it made my life easier". (Attendee 19_male)

During the focus groups, doctors reported they were more likely to read the GMC guidance and documents now. They felt that WtUKP had brought the documents to life and highlighted their relevance. It was notable that very few doctors reported having read any of the GMC documentation before the WtUKP workshop.

¹ A repeated measures ANOVA with a Greenhouse-Geisser correction found a significant main effect of time, $F(1.58, 284.70) = 102.38$, $p < .001$, partial eta squared = .36. Bonferroni post-hoc tests found that there was a significant increase in the aggregated score of 'understanding of GMC guidance' between pre (mean = 5.43, SD = 1.05) and post-tests (mean = 6.48, SD = .54, $p < .001$).

“I think I’m more likely to look at the documents now seeing how they are used, because when you are presented with this overwhelming amount of information the first thing you do is file it.” (Focus Group London, L/24)

Table 5. Table illustrating attendee perceived understanding about specific GMC guidance pre (n=324) and post (n=381) WtUKP (paired sample t-test on full data sets only)

Item (7=high)	Pre-WtUKP		Post-WtUKP		T-tests		
	Mean	SD	Mean	SD	t	df	p
GMC1 When I have a professional dilemma, I will consult GMC guidance	5.88	1.016	6.61	.558	-13.27	303	<.001
GMC2 I understand how to apply GMC guidance on consent	5.17	1.333	6.40	.599	-16.17	304	<.001
GMC3 I understand how to apply GMC guidance on confidentiality	5.39	1.316	6.40	.600	-13.61	303	<.001
GMC4 I understand how to apply GMC guidance on how to raise a patient safety concern	5.17	1.334	6.35	.678	-1.02	302	<.001

Overall, non-attendees scored slightly lower in their perceived understanding of GMC guidelines than attendees for both pre- and post- WtUKP. Given that the majority of this group were in practice, this might suggest GMC guidance is not always emphasised in practice. RAs further commented that one of the biggest impacts for doctors attending the workshop was going through the GMC guidance.

“It’s something that people don’t talk you through, even at work... that was quite useful because it gives you an idea about how important confidentiality matters are in this country. That was probably an eye-opening thing...” (Attendee 13_male)

“I think the biggest thing is knowing where to find the answers. Knowing the GMC has some really good materials that they can find the answers to”. (RLA 1_female)

4.3.3 Increased understanding of UK practice and the NHS

A series of paired samples t-tests were conducted to test for differences between pre- and post-items related to practising in the UK (table 6). As already illustrated, scores had been relatively high pre-WtUKP. However, following WtUKP, there was still a statistically significant increase for the majority of the items (excluding multidisciplinary team working). This suggests the attendees’ perceived awareness and understanding of UK practice had improved. This was supported by attendee interviews, reporting that WtUKP raised their awareness of gaps in their knowledge about UK practice and alerted them to their learning needs. Doctors stated that they were clearer and more confident regarding asking for help and raising concerns.

“I would say the welcome to UK Programme was very, very helpful in settling into the UK ways of practice. I would say it also helped to prepare me for patients after you treated them, polite ways of saying no problem, so communicating...then of course it also helps to know that, as much as possible we should be willing to ask for help especially if you need to, especially on drug prescriptions...if you feel like you don’t know it you should ask for help or raise a patient concern”. (Attendee 1_male)

Improvement in perceived understanding was greatest for the items where scores had been lowest prior to WtUKP: *understanding the structure and hierarchy of the NHS and being aware of how to challenge poor behaviour of a senior colleague*. However, these areas still had the lowest scores post-WtUKP. One possible

reason is that these areas were not explicitly covered within WtUKP. The structure and hierarchy of the NHS is not easy to comprehend as an overseas qualified doctor, and challenging seniors is universally difficult, possibly more so if the original training involved working in a more hierarchical environment. Whilst confidence to ask seniors for help during practice was expressed following attendance of WtUKP, more understanding and signposting on how to challenge behaviours may be needed.

“I admit I still don’t fully understand how it works...at least I know that if there is an issue I will ask my senior...at least I am aware that this is an area where I have to seek advice from people who know better. But I have to tread carefully”. (Attendee 17_male)

“...transparency about mistakes is not always there, it’s not in the culture itself, here it is really different, transparency about mistakes and problems, and so on and this should be clarified from the beginning that this is the way the game is played here. It’s just one of the things they should have clarified for all the newcomers because it’s not very clear to all of them”. (Attendee 7_male)

Table 6. Table highlighting attendee perceived understanding about UK practice and the NHS pre (n=389) and post WtUKP (n=393) (paired sample t-test on full data sets only)

Measures/Scale	Pre-WtUKP		Post WtUKP		T-test		
	Mean	SD	Mean	SD	t	df	p
I am aware I will need to adjust my practice to fit the UK medical system (7=high)	6.37	.870	6.51	.798	-3.434	367	.001
I am aware of the challenges I may face practising medicine in the UK (7=high)	5.87	1.122	6.36	.780	-9.160	366	<.001
I feel able to deal with cultural differences that I may face in practice (7=high)	4.38	1.561	4.58	1.550	2.282	358	.023
I understand the structure and hierarchy of the NHS (7=high)	2.80	1.640	3.65	1.757	9.778	363	<.001
I am comfortable working as part of a multidisciplinary team i.e. working in a team with other doctors, nurses, health care assistants etc. (7=high)	6.61	.711	6.64	.539	-.867	366	.387
I am comfortable asking others for help if needed (7=high)	6.53	.805	6.67	.548	-3.731	362	<.001
I understand how to communicate with patients’ relatives (7=high)	6.00	.894	6.21	.834	-4.745	360	<.001
I am aware of how to challenge poor behaviour of a senior colleague (7=high)	2.71	1.605	3.91	1.803	11.308	359	<.001
I am aware of the need to be open and honest with patients following an error or mistake (7=high)	6.44	.808	6.78	.431	-7.903	364	<.001

It is interesting to note that one of the key reasons non-attendees had originally signed up for WtUKP was because they wanted to have a better understanding of how the NHS worked and learn more about the expectations of working as a doctor in the UK.

“We signed up to get more information about how the NHS works, and how we would best find our place within the NHS”. (Non-attende 7_female)

The non-attende group scored lower in their perceived understanding and awareness on all items relating to NHS practice compared to attendees post WtUKP, and scored slightly lower on the majority of items compared to attendee scores pre-WtUKP. This again highlights that WtUKP content is unlikely to be gained from practice.

4.3.4 Patient Centeredness and communication

The results in table 7 indicate a significant increase in perceived patient centeredness (both sharing and caring subscales) and communication self-efficacy. A statistically significant change over time was found, particularly highlighting an increase between pre and post scores for all areas.² This suggests that WtUKP increased understanding about care and compassion, shared decision making, and increased communication skills self-efficacy. These findings might further translate into practice, since the data suggests that doctors had more understanding about adapting to the UK culture of seeing the patient as a partner.

Table 7. Table illustrating attendee scores for validated scales assessing self-reported patient centeredness and communication self-efficacy pre, post and three months following WtUKP (analysis: Mean, SD and n for sample used in repeated measures ANOVAs, based on complete set of 3 data points for each scale – pre/post/follow-up)

Measures/scale	Pre WtUKP		Post WtUKP		Bonferroni post-hoc
	Mean	SD	Mean	SD	
PPOS Global; patient centeredness (n=180) (6=high)	3.41	.49	3.58	.56	P < .001)
- PPOS Sharing; shared decision making (n=198) (6=high)	3.23	.64	3.44	.73	P < .001)
- PPOS Caring; care and compassion (n=186) (6=high)	3.58	.49	3.69	.54	P < .001)
Communication self-efficacy (n=202) (6=high)	3.86	.62	4.15	.61	P < .001)

The non-attende group scored similar to the attendee group pre-WtUKP on self-reported understanding with regard to patient centeredness, yet slightly higher with regard to levels of communication self-efficacy. Non-attendees appeared to score lower than attendees on all scales post-WtUKP. This again suggests non-attendees need WtUKP, even though most are in practice (particularly regarding patient centeredness). Attendees highlighted the importance of learning about these areas in WtUKP, recognising themselves that they were more aware of the importance of being patient-centred and communicating effectively with patients.

“Patient centeredness and communicating with patients, particularly being open and honest. I would like to talk to patients/relative more than what I usually do”. (Attendee post questionnaire free text comment)

² To test for change over time, a one-way repeated measure analysis of variance (ANOVA) with a Greenhouse-Geisser correction was conducted to compare scores across all time points (pre, post and follow up) on PPOS Global (patient centeredness). The results indicated that there was a significant main effect, $F(1.42,254.73) = 10.27, p < .001, \text{partial eta squared} = .05$.

This was repeated for the POS subscales, with Greenhouse-Geisser correction. For PPOS Caring there was a significant main effect, $F(1.55,286.66) = 4.38, p = .021, \text{partial eta squared} = .02$. For PPOS Sharing there was a significant main effect, $F(1.43,280.67) = 10.24, p < .001, \text{partial eta squared} = .05$.

There was a significant main effect (Greenhouse-Geisser correction) across all time points on Communication self-efficacy Skills, $F(1.65,332.10) = 33.79, p < .001, \text{partial eta squared} = .14$.

Interviews with attendees also revealed that when participants reflected on overall differences between the UK healthcare practices and the healthcare practice in their own country, reflection often centred on communication with patients and patient centred care. The topic of prescribing for friends and family was also highlighted as an area that was practiced differently in other countries and discussed during the workshop. Other areas that doctors reported as raising awareness with regard to differences in healthcare practices were related to being open about mistakes.

“Yeah it did help because obviously coming from a different country and practising, and trained in a different country in a different way though the content remains the same, but obviously, the approach and the way of dealing with things over here is definitely different. So, I think the Welcome to UK Practice was very useful to taking the first steps towards practising in this country”. (Attendee 15_male)

4.3.5 Benefits of socialising and networking during WtUKP

RLAs reported that socialising and networking with other overseas-qualified doctors was an important aspect of WtUKP, and that it needed further development. Supervisors also saw the benefit of networking opportunities through reflections from their supervisee on the workshop.

“The most important part of the day is the opportunity for the doctors to meet each other, network and swap war stories” (RLA 12_female)

“He attended the GMC Welcome to UK. I’m not too sure what he learnt. I know he liked it because it was a good networking opportunity as well. Reassuring for him to meet other doctors going through the same thing”. (Supervisor 15_Female)

Some attendees in both interviews and focus groups reported that they had been able to interact and socialise on the day with other overseas doctors. They commented that this had been valuable and that they had found it useful to talk to other doctors who were from different backgrounds, and to know that other doctors were experiencing similar things to them. Doctors commented that they had found it interesting to see how other doctors adapted to working in the UK and it helped reduce isolation. An increase in confidence was also reported.

“I think the most important thing was to see how people from many different backgrounds come to the UK and how we all have to adapt to working together. I think that’s really valuable to know all of us are struggling to start working in the UK.” (Attendee 4_male)

“It instilled a sense of confidence in me. I came travelling 45000 miles, I was alone and on the very first day there were people talking to me and they were sensitising me about the possible challenges I may face in my practice and it was quite nice to be frank.” (Attendee 12_male)

Some of the doctors reported making contacts on the day and said that they have kept in touch with them. Either via phone or email or have met up if they have been in the same hospital or geographical area. However, time and busy work schedules was reported to hinder this. Researchers who attended the WtUKP workshops also observed this.

“So, I am in touch with a couple of people who I met here and it’s good to know people actually because I didn’t know anyone at all before coming here. So, at least in the initial days before you are in process of making new friends at your work place, you have someone to chat with on weekends so it’s nice...Yeah, we got telephone numbers and emails.” (Attendee 12_male)

However, many participants reported that they would have liked more chance to socialise and network during the workshop. Many attendees suggested providing refreshments after the workshop so that participants could network informally.

“Well we didn’t have enough time to actually have a chat, but I think the overseas Doctors were already working in the UK and I just met them and that’s it and have my chat, I think if we had some time to interact with each other that would be a good idea and maybe tying up the workshop as that”. (Attendee 5_male)

4.4 Evaluating long term impact on outcomes (at three-month follow up)

4.4.1 Reported changes in awareness of UK practice following WtUKP

Immediately after attending WtUKP, 67% of the attending doctors reported that they intended to change their practice. Of the 284 doctors who completed the three month follow up questionnaire, 176 (62%) reported that they had changed their practice as a result of what they had learnt at WtUKP.

Interestingly, of the 108 doctors that had reported no change in practice, 52/108 (48%) had actually stated an intention to do so (recorded post-WtUKP). This suggests that whilst the doctors may have had intention to change, barriers in practice may have prevented the change taking place. Questionnaire data and interviews identified some of these barriers, including; fitting in with the cultural and regulatory norms in the UK, putting learning into practice in a busy clinical environment, and being unable to get the support and feedback from colleagues they needed. However, it may also be that doctors had not been in practice for a long enough duration for change to be identified.

Qualitative data helped us to understand the areas of practice WtUKP had impacted on the most. Doctors primarily reported changes in the way they perceive issues around consent and confidentiality. Another area that doctors reported change in their practice was with regard to communication with patients. This reflects the significant improvement in scores between pre and post-WtUKP using the validated measure that assessed communication.

“I had an incident in the hospital where I am, I am attending to people with specific injuries...I had to find out the policy of the hospital, basically had to ask...and the patient might not be competent of answering. I've had to find ways to read through the guidelines to at least tell them to make sure we are sure that whatever result comes from the investigation the hospital policy is confidential and you get a superior involved in the incident.” [Attendee 1_male]

“I have patients not all having mental capacity and welcome to UK practice has actually pointed it out and helped me find out who to raise the concern to and how to approach these cases, like asking for the best interest...Taking consent from everyone before examining the patient and asking confidential matters. Also, patient confidentiality which is not actually followed back in my country. These are the things that are very sensitive over here and was helpful to know about.” (Attendee 15_male)

“I was totally new to those scenarios. Back home it is normal to prescribe drugs to anyone or to self-prescribe but here in the UK you are a doctor, but you cannot self-prescribe you have to go to a GP.” (Attendee 17_male)

“...a very helpful introduction to how doctors in the UK work and how they interact with their patients because the Doctor patient relationship seems to be quite different...they wouldn't address us, and we wouldn't address patients by their first names and here it's much more collegial relationship I find”. (Attendee 4_male)

4.4.2 Perceived understanding of GMC guidance after three months

At the three-month follow-up, doctors' reported that likelihood to consult GMC guidance and understanding of how to apply it had dropped significantly (see table 8 below).³ There was also a significant decrease in understanding the role of the GMC (see Table 9). This suggests that reinforcement and reflection about specific WtUKP content and the GMC may not be in place and therefore doctors may be unable to sustain learning (this is discussed more throughout the report).

³ As well as looking at an overall main effect of time, specific ANOVAs were run across the different time points. Bonferroni post-hoc tests found that there was a significant increase in the aggregated score of 'understanding of GMC guidance' between pre and follow-up tests (mean = 6.10, SD = 65, $p < .001$), but there had been a significant decrease for post to follow-up on all items ($p < .001$).

Despite the reported decay with regard to GMC guidance, scores at follow up were still significantly higher compared to baseline³. 70% of attendees had reported that they had been using GMC guidance in the follow up questionnaires. Others gave specific examples of how they applied learning.

“I have become more open minded and I tend to explore patients concerns more than I used to do before”.
(Attendee follow up questionnaire free text comment)

“I have been more confident in dealing with patients and try to carry a patient-centric approach”.
(Attendee follow up questionnaire free text)

Furthermore, the doctors reported scores were very high post WtUKP (almost at the top of the scale; 7). It is therefore possible that the doctors were feeling highly confident after the workshop and the significant drop (still >6) is more a reflection of confidence in using the GMC guidance once back in practice when they were required to apply learning without the GMC support they received during WtUKP.

Table 8. This table highlights the difference in attendee scores between post WtUKP and follow up with regard to GMC guidance (n=217) (paired t-test results presented)

Item	Post-WtUKP		Follow-up after WtUKP		T-tests		
	Mean	SD	Mean	SD	t	df	p
GMC1 When I have a professional dilemma, I will consult GMC guidance	6.57	.566	6.12	.881	6.853	215	<.001
GMC2 I understand how to apply GMC guidance on consent	6.33	.674	6.00	.742	5.405	216	<.001
GMC3 I understand how to apply GMC guidance on confidentiality	6.32	.706	6.12	.741	3.350	215	<.001
GMC4 I understand how to apply GMC guidance on how to raise a patient safety concern	6.30	.786	6.06	.727	3.584	216	<.001

4.4.3 Perceived understanding of UK practice and the NHS after three months

Slight decay was also evident for the majority of items related to the doctors' reported understanding of UK practice and the NHS. However, a significant decrease was only found in one area; *being aware of the need to be open and honest with patients following a mistake* (although still relatively high overall at follow up). Despite the biggest improvement, scores for the items focused on *challenging seniors* and *understanding about NHS structure* remained the lowest (see Table 9 below).

Despite some decay, there was still improvement in perceived understanding at follow up compared to baseline scores. However, this was not the case for three items; awareness of the *need to adjust practice to fit in with the UK medical system*, *being comfortable working as part of a multidisciplinary team*, and *feeling comfortable asking others for help*, which saw slight decreases at follow up compared to baseline scores.

Table 9. Table illustrating attendee scores concerning practice in the NHS, comparing post-WtUKP and three-month follow up data (n=224); paired sample t-tests presented

Item	Post-WtUKP		Follow-up after WtUKP		T-test		
	Mean	SD	Mean	SD	t	df	p
I am aware I will need to adjust my practice to fit the UK medical system (7=high)	6.49	.825	6.28	1.023	2.509	223	.013
I am aware of the challenges I may face practising medicine in the UK (7=high)	6.41	.734	6.25	.741	2.460	223	0.15
I understand the role of the GMC (7=high)	6.45	.702	6.16	.736	4.454	222	<.001
I feel able to deal with cultural differences that I may face in practice (7=high)	4.58	1.614	4.68	1.409	.736	222	.463
I understand the structure and hierarchy of the NHS (7=high)	3.62	1.809	3.93	1.562	2.084	222	.038
I am comfortable working as part of a multidisciplinary team i.e. working in a team with other doctors, nurses, health care assistants etc. (7=high)	6.64	.551	6.50	.709	2.487	222	0.14
I am comfortable asking others for help if needed (7=high)	6.62	.571	6.49	.753	2.353	222	.020
I understand how to communicate with patients' relatives (7=high)	6.16	.919	6.12	.696	.572	218	.568
I am aware of how to challenge poor behaviour of a senior colleague (7=high)	3.92	1.820	3.81	1.661	-.773	222	.440
I am aware of the need to be open and honest with patients following an error or mistake (7=high)	6.78	.429	6.54	.702	4.325	222	<.001

4.4.4 Patient centeredness and communication after three months

Post WtUKP scores in the validated scales measuring patient-centeredness (shared decision-making and care and compassion) and communication self-efficacy were largely maintained at three months, there being no statistically significant decrease found (see table 10 for mean scores). We might speculate that while patient centeredness is observed and rehearsed in practice, GMC guidance is not. Although mean scores were slightly higher at follow up compared to baseline, no statistically significant increase was found between pre and follow up scores on the validated scales. This suggests the impact of WtUKP on these areas long-term may be smaller overall in comparison to understanding of GMC guidance.⁴ The data indicates that the overall effect was driven mainly by the pre/post difference.

⁴ No statistically significant difference was detected between the pre and follow-up test and between the post and follow-up test. Bonferroni post-hoc tests further found that there was no statistically significant difference detected between the post and follow-up test for communication self-efficacy scores.

Table 10. This table illustrates mean scores and SD for attendees on the validated scales post WtUKP and follow up

Measures/scale	Post WtUKP (n=382)		Follow up (n=245)	
	Mean	SD	Mean	SD
PPOS Global; patient centeredness (6=high)	3.58	.56	3.49	.56
- PPOS Sharing; shared decision making (6=high)	3.44	.73	3.35	.72
- PPOS Caring; care and compassion (6=high)	3.69	.54	3.67	.54
Communication self-efficacy (6=high)	4.15	.61	4.15	.52

4.4.5 Supervisor views on WtUKP

All supervisors were interviewed after the doctors had attended WtUKP and reported no issues in most areas covered by WtUKP such as consent, confidentiality, and mental capacity. However, they did note difficulty in other areas not covered such as workplace bullying (discussed below in WtUKP content). It is worth noting that most of the supervisors reported not being aware of the WtUKP workshops or its content, and none of them were aware that their supervisees had attended it. As a result, supervisors could not attribute any change in these doctors' performance to attendance at WtUKP. All supervisors reported that WtUKP was welcomed, however, there were other factors that played a role in supporting the transition of overseas doctors to the NHS workplace. For example, the training environment and on-going support.

"None of us have a clue what they do in the Welcome to practice bit...Or how to build on that. It's the issue of ongoing support. So half a day is great, if everyone is building on that. Referring back to it. But if it's just in isolation, then that's a problem." (Supervisor 4_Female)

4.5 Perceptions of the GMC

Data from the questionnaires indicates that after attending WtUKP, doctors agreed more strongly that the GMC is supportive of them. Pre and post questionnaire data showed that 31% of attendees indicated that their perception of the GMC had changed following WtUKP. Table 11 highlights a significant increase in feeling supported by the GMC, although this was relatively high prior to WtUKP. Feeling the GMC is supportive may result in doctors asking the GMC for advice.

Table 11. Table illustrating attendee perception of the GMC pre and post WtUKP (paired sample t-test on full data sets only)

Measures/Scale (7=high)	Pre-WtUKP (n=360)		Post-WtUKP (n=360)		T-Test		
	Mean	SD	Mean	SD	t	df	p
I feel the GMC are supportive of doctors	5.45	1.40	5.83	1.26	-6.051	359	<.001

Interview data highlighted mixed views on the GMC by participants who had attended the WtUKP workshop. Many doctors who had attended WtUKP were positive about the GMC, seeing their primary role to help patients as positive and compared the GMC favourably to their own regulatory body. They commented that having a good

regulatory body helped to drive up standards and public trust within the profession. Many attendees reported that after attending the WtUKP they saw the GMC in a more positive light.

“I feel positive about the GMC after today, but then I also have a lot of questions in my head, I would not want to make a mistake”. (Focus Group London, L /14)

However, other attendees maintained negative views of the GMC. A commonly held view by these doctors was that the GMC holds more of a disciplinary role than a supportive one (this was often in reference to a WtUKP workshop slide, which outlines the role of the GMC).

“The GMC declared clearly that they are not to support doctors but they support patients!” (Attendee follow up questionnaire text)

“My view about the GMC in this country has not changed...they’ve been protector of patients...even at risk of being seen negatively by Medical Practitioners”. (Attendee 1_male)

Non-attendees and supervisors tended to harbour more negative perceptions of the GMC than those who had attended a WtUKP. This negative perception outside of WtUKP may explain the significant decrease in perceived support from the GMC at follow up, which was in fact slightly lower at follow up compared to baseline (see table 12).

“Most of the things I hear about GMC is this doctor has been struck off, this doctor has been punished, so it’s difficult. I’ve not had any problem with the GMC and I pray I don’t have, but sometimes it does make you a bit scared”. (Non-attendee 4_male)

“They won’t consider the pastoral needs of the doctor making a transition at all. They see their job as a regulator. There seems to be something missing. The pastoral support. I don’t think the GMC are perceived as supportive and what they publish comes across in a dictatorial and regulatory tone”. (Supervisor 8_Female)

Table 12. Table illustrating attendee perception of the GMC post and follow up WtUKP (paired sample t-test on full data sets only)

Measures/Scale (7=high)	Post-WtUKP (n=224)		Follow-up after WtUKP (n=224)		T-Test		
	Mean	SD	Mean	SD	t	df	p
I feel the GMC are supportive of doctors	5.83	1.281	5.09	1.364	7.297	221	<.001

However, RLAs reported that WtUKP facilitated improved relations with those who had attended the workshop.

“Normally for foundation doctors...they’ll either meekly smile and walk past, or they’ll scurry away...Even if they’ve had a nice interaction with me, I’m still the lady from the GMC. Whereas the international doctors who’ve been on Welcome to UK are far more likely to make an effort to come over and say hello” (RLA 5_Female)

4.6 The wider environment and factors that impact transition to UK practice

4.6.1 Challenges facing overseas doctors that impact on transition

The findings highlighted the complexity of a doctor's transition to the UK workplace. When asked at follow up what the most challenging aspects of adjusting to living and working in the UK were, all participants highlighted areas related to *working in a different legal framework, understanding the NHS structure, UK culture, finance, finding accommodation and social aspects*. Social aspects were reported to be particularly challenging.

"So, this is my first time in another country and I'm here alone and the first challenge is loneliness but here a lot of my colleagues are quite helpful. The consultants and the supervisors here are also supportive at the hospital, but sometimes I do get quite lonely". (Attendee 16_female)

"Life outside the hospital has been a challenge for me, it's not the same for everyone but I really found the hospital area relaxing and welcoming for me and this was the place I felt like this is my place, this is where I'm supposed to be. But outside it has been harder for me and I don't think that this is the GMC's role to help us out with our personal lives". (Attendee 19_male)

Supervisors commented further that whilst doctors may be clinically ok, they found it more challenging to settle outside of work. If the doctors had support from family and friends in the UK, this aided their transition. Having a social network in the UK helped reduce isolation and loneliness.

"Clinically most often get up to speed, but then there are the guys who face social barriers. Picking up the local barriers and subtle hints is hard and takes time. But the GMC should make it clear that supervisors should identify these particular candidates, those who may struggle more. Those who don't have that safety net of family and friends [and] really get thrown in the deep". (Supervisor_7_Female)

Some attendees commented that it had taken quite a long time to settle into work. This was mainly due to understanding and becoming familiar with new systems, managing the paperwork and understanding expectations. Many things are often not clear, for example; referral procedures, staff roles and responsibilities, the level they are expected to be working at, and the hours they are expected to work (contracted or not). Attendees did not feel this content was covered during WtUKP. This is likely to be more of an organisational issue once doctors are in the workplace, highlighting the need for organisational support once in practice.

"So, for me after two weeks I was given a clinic here on my own and for me to understand the flow of work here is different, so that was a big challenge. Like who do you refer to, how do you refer? So, two weeks of induction and straight in doing solo clinics.... So, if more information was given to me simple things, because the medical background is the same it's just the plan. Like your support for this is here, and what I can do, and cannot do, because in my country there are physiotherapists and they do different things, additional things. Whereas here they stop at certain things and they don't intervene". (Attendee 20_female)

The findings were similar for both attendees and the non-attendee group. Following WtUKP, doctors additionally needed advice on clinical documentation and about questions related to their post and practice. For example, referral procedures, staff roles and responsibilities, team working and the hours they were expected to work.

Doctors reported on the challenges of dealing with visa applications and obtaining all the relevant documentation prior to registration and starting work. Some doctors also reported having to fly into the UK for ID checks but then not being able to attend WtUKP at the same time and the expenses of returning for this later.

"Then on arriving to the UK I had some trouble with the office where I had to do all my paperwork, so I believe they asked me so many questions that I didn't know the answer to then, such as do you have a DBS? Do you have a National Insurance Number? Where is your contract? Your accommodation? Could you get the contract that you've signed with the Landlord?" (Non-attendee 8_female)

Some non-attendee doctors, who came with clinical experience, discussed their frustration at not having their experience recognised, and either having to restart their training or not getting a training post at all. Others were told not to bother seeking a training number, as the training was too long.

4.6.2 *Negative experiences during practice*

A number of the data subjects reported negative experiences of discrimination and bullying (from both patients and staff). During the focus groups doctors talked about experiencing racism. Many had asked seniors for advice about how to deal with this. Unfortunately, the responses from seniors were not always supportive.

"I have a friend who had a patient said, get your black ugly face out of here... and then the consultant said she should go back and apologise to the patient". (Focus Group London, L/14)

"I told my supervisors [about racism] and he said this is part of the learning process". (Focus Group London, L/14)

Doctors further reported that they had experienced bullying, undermining, and negative behaviours from their seniors.

"Yeah they gave me a hard time actually like attacking me 'you should have done this and I'm like I'm new here I've just started' and they are 'no you've been here for a week". (Focus Group London L/24)

"I see a lot getting mistreated badly by seniors, which is not as common, but a lot by their peers.... They are also at risk for having blame put on them and not knowing how to handle themselves when faced with undermining behaviour". (Supervisor 2_Male)

Doctors wanted information on how best to deal with these behaviours.

"I would love to know more on how I can be more supported when I start working because I had a nightmare and I hated working the first week and many of my colleagues say, 'this person is normal don't take it personally" (Focus Group London, L/24)

Non-attendee doctors also reported negative experiences from colleagues, seniors and patients. Knowing what to do on these occasions was not always clear to them and some managed this by keeping silent.

"When you clearly have somebody bullying you because I didn't know, and those things happened to me and I'd forgotten about that, but they made things stressful because you feel like you don't know the system and they can shout at you and they can do anything and get away with that. That's the main area I would have loved to get more information on what to do in a situation like that." (Non-attendee 4_male)

Negative experiences in practice were not covered in WtUKP and this was recognised by RLAs as a concern, but in the available time, RLAs stated bullying and racism was not an area they could cover. RLAs also stated that if racism originated from the patient, this needed a different approach.

"On the subject of bullying it might be nice to try and allay some fears but again that would be easier done if the program was a full day program." (RLA 3_male)

4.6.3 *The importance of ongoing support when in practice*

Many of the doctors had felt isolation and loneliness, and reported a clear need for support from colleagues and supervisors. Advice from colleagues who had also qualified overseas could be particularly beneficial. The supervisors and RLAs also acknowledged these issues faced by overseas doctors and how important support from colleagues was in helping to overcome them. Sadly, both overseas doctors and their supervisors noted at times that this support was absent in practice, which hindered and discouraged them from asking for help in practice.

“We need supportive, kind and warm environment rather than discrimination”. (Attendee follow up questionnaire free text)

“Maybe other IMGs working in the NHS. People also just talk about simple things, like where to buy halal meat, how to open a bank account. That would be helpful as an ongoing thing” (Supervisor 1_Male)

“She got very little in the way of support from her colleagues... I would ask where she was, and there would just be a roll of the eyes and a tut...they didn’t appreciate the support she needed” (Supervisor 8_Female)

The data suggested encouraging reported improvements initially following WtUKP, for example more awareness of the need to ask others for help and raise concerns to seniors. However, a number of doctors commented that they would still like to know more from WtUKP, especially in relation to managing difficult situations. Although there was an initial increase in confidence directly following WtUKP and perceived support in these areas, this may not have been maintained in reality during practice. The data further suggested overseas doctors were unaware of *how* to raise concerns about senior colleagues and challenge their behaviour (both attendees and non-attendees). WtUKP did not explicitly cover this issue.

“Young clinicians like me fear working in the NHS and do not feel able to raise concerns rightly.” (Attendee follow up questionnaire free text)

“We come from systems where medicine and the curriculum is very different. Guidance or information on where we fit in is not something that is well covered. Secondly, the fear of litigation/ making mistakes is intimidating and makes it harder to fit into the system quickly”. (Attendee follow up questionnaire free text)

This lack of ongoing support and feeling fearful of making mistakes may also be a reason why some doctors felt unable to apply their learning from WtUKP into practice three months following WtUKP. Whilst the qualitative data supports the finding that attendees became more aware about the need to be open and honest, ask for help, and raise concerns directly following WtUKP, the doctors may not acquire the confidence or knowledge about *how* to do so; particularly if they feel unsupported in practice.

“I’m quite aware that if something happens I need to raise an alarm or concern... So, the UK practice was very helpful in sensitising me what are the challenges ahead. But you feel under confident whether you will be able to deliver or not. It also was very helpful that I got to learn there will always be somebody to help me, like there are people around me whom I can contact.” (Attendee 12_male)

This would help to explain any decay three months following WtUKP, for example *being open and honest with patients*. Supervisors, RLAs and overseas doctors suggested permitting a period of observation in clinic before practising and having a mentor or peer-buddy.

“They should be supported by their Trust, like giving them onsite accommodation for the initial transition period and some kind of mentorship programme.” (Non-attendee 8_female)

“They need cultural orientation. I think a half-day induction is very very short. It’s not just about patients, it’s about interacting with other members of staff as well. I think just a little bit more time will stop them getting into trouble. Often, they don’t know how to communicate and that’s the biggest focus...very often the people that get into trouble, its communication. More time invested at the beginning will save a lot of trouble further down the line”. (Supervisor 16_Female)

Supervisors also reported that it would be helpful to know about the content of WtUKP so that they could monitor individual learning and facilitate development following attendance.

“It would be helpful for supervisors to know what the induction involves, so more linking. If we could find out what it is. It would be useful for us to know what they should have grasped from what has been given”. (Supervisor 15_Female)

This is particularly important for those who may lack self-awareness. For example, some individuals stated they did not apply their learning from WtUKP into practice because they felt they did not need to.

“I haven’t encountered a scenario in which I need to use the skills I learnt from the workshop.” (Attendee follow up questionnaire free text)

Supervisors also stated that they felt ill prepared to support overseas qualified doctors and at times felt ‘out of their depth’, as they were unsure of the needs of overseas doctors. In some cases, only when concerns arose in practice did they assess individual learning needs.

“There needs to be something as well for supporting trainers. I have been a consultant for 20 years and an educational supervisor for probably about 18 of them, and I felt completely out of my depth. I have supervised multiple trainees with differing needs, I’m not naive, but I really felt out of my depth. It didn’t prepare me for this. We need some support and maybe having a network of trainers who are prepared to take on these trainers, a network within each Trust who we could turn to, who have had experience and aware of the resources available, who would be able to provide leadership and be a point of contact to support the trainers. I felt I didn’t do my best. I was so concerned about anything that could be misconstrued and upset her. The clinical stuff is often not the problem, it’s the cultural stuff they struggle with”. (Supervisor 8_Female)

The use of the learning log would likely support supervisors to identify their supervisees’ needs. During observations researchers noted that the majority of attendees did not use the learning log provided to them during WtUKP. Both attendees and supervisors felt more emphasis should have been placed on this by RLAs, to support ongoing reflection and personal development.

“They do a half day course and say you need to fill in a learning log, but then they don’t follow it up, and we know it’s follow-up that they need”. (Supervisor 4_Female)

This decay evident at follow up, particularly concerning GMC guidance, may ultimately reflect the fact that the issues covered in WtUKP are not experienced or reinforced in practice. The learning from WtUKP needs to be reinforced in practice from seniors and supervisors. This starts with doctors knowing about the additional needs of their overseas colleagues and working with them to support a successful transition.

4.6.4 Comparison of those in practice and those not in practice following WtUKP

The quantitative data further highlighted the need for support in practice. Those in practice at three months following WtUKP scored similar to those not yet in practice on most items (see table 13). Compared to those not in practice, attendees in practice scored significantly lower in their reported understanding of how to apply GMC guidance and shared decision making. This is interesting as we might have expected that those in practice would have an increased understanding compared to those not yet in work. However, it is reassuring to see that the scores have improved in all areas (apart from multidisciplinary team working) at the follow up stage for both groups of doctors, compared to baseline (see table 2 for comparison). The majority of scores relating to understanding of NHS practice and GMC guidance are relatively high for both groups following WtUKP, regardless of whether in practice.

Table 13. Table illustrating mean questionnaire scores for attendees of WtUKP at three-month follow-up, comparing those in practice (n=120) and those not in practice (n=98); independent sample t-tests are presented

Measures/Scale	Attendees in practice following WtUKP		Attendees not in practice following WtUKP		T-Test		
	Mean	SD	Mean	SD	t	df	p
Communication (5=high)	4.21	.506	4.13	.512	1.079	207	.282
PPOS global: Patient Centeredness (6=high)	3.42	.571	3.58	.539	1.957	207	.052
- PPOS Shared decision making (6=high)	3.13	.730	3.45	.705	2.338	207	.020
- PPOS Care and compassion (6=high)	3.36	.562	3.71	.520	.920	207	.359
Awareness of GMC guidance (7=high)	5.99	.616	6.16	.573	-2.084	216	.038
I am aware I will need to adjust my practice to fit the UK medical system (7=high)	6.35	1.010	6.30	.922	.409	216	.683
I am aware of the challenges I may face practising medicine in the UK (7=high)	6.23	.796	6.29	.674	-.517	216	.605
I understand the role of the GMC (7=high)	6.14	.702	6.18	.791	-.415	216	.678
I feel able to deal with cultural differences that I may face in practice (7=high)	4.68	1.342	4.68	1.496	.045	216	.964
I understand the structure and hierarchy of the NHS (7=high)	3.96	1.508	3.95	1.627	-.044	216	.965
I am comfortable working as part of a multidisciplinary team i.e. working in a team with other doctors, nurses, health care assistants etc. (7=high)	6.50	.635	6.50	.803	.000	216	-
I am comfortable asking others for help if needed (7=high)	6.43	.695	6.53	.815	-.915	216	.343
I understand how to communicate with patients' relatives (7=high)	6.15	.644	6.08	.755	.721	216	.471
I am aware of how to challenge poor behaviour of a senior colleague (7=high)	3.84	1.685	3.90	1.589	.252	216	.802
I am aware of the need to be open and honest with patients following an error or mistake (7=high)	6.53	.549	6.52	.864	.048	216	.962
I feel the GMC are supportive of doctors (7=high)	5.00	1.396	5.30	1.318	-1.596	216	.112

At follow up, whether in practice or not, doctors reported a significant decay in awareness of GMC guidance (see table 14). This suggests GMC guidance may not be reinforced in practice. However, further research would be needed to fully explore this. Interestingly, doctors in practice demonstrated a slight drop in understanding of patient centeredness, while the scores of those not in practice in this area were largely maintained.

Table 14. Table to illustrate perceived understanding of GMC guidance for attendee doctors in practice vs those NOT in practice three months after WtUKP

Measures/scale	Post WtUKP in practice (n=203)		Follow up WtUKP in practice (n=203)		Post WtUKP NOT in practice (n=162)		Follow up WtUKP NOT in practice (n=162)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
PPOS Global; patient centeredness (6=high)	3.53	.616	3.42	.571	3.59	.551	3.58	.539
- PPOS Sharing; shared decision making (6=high)	3.37	.819	3.22	.729	3.45	.707	3.45	.705
- PPOS Caring; care and compassion (6=high)	3.70	.565	3.63	.562	3.72	.501	3.71	.520
Communication self-efficacy (6=high)	4.22	.551	4.21	.506	4.18	.616	4.13	.512
Awareness of GMC guidance (combined scale) (7=high)	6.36	.584	5.99	.616	6.43	.566	6.16	.573

4.6.5 Individual differences

Overall attending WtUKP seemed to benefit all doctors irrespective of where they had trained, whether they were in practice or not, and length of time in the UK. Improvements in knowledge about the GMC and understanding about UK practice, following WtUKP, were evident in both the EEA doctors and IMGs. Full analysis showed no statistical differences between EEA doctors and IMGs across any datasets. However, it was noted that IMGs tended to have more awareness about *Good Medical Practice* due to previous exposure to the Professional and Linguistic Assessments Board (PLAB) exam. Supervisors also reported that they often made assumptions about trainees' ability based primarily on their language skills and level of clinical training, assuming competence (when language was good) rather than checking it. Furthermore, EEA doctors illustrated in focus groups a lack of awareness about concepts such as the use of chaperones, which are further covered in the PLAB exam.

Individual motivation and readiness to learn were highlighted as important for these doctors during interviews with overseas doctors and supervisors. In terms of WtUKP, motivation is important to ensure doctors engage with the learning and go on to apply this in their practice. Not having the readiness to learn, for example feeling they do not need the training or feeling they already know the content, would likely hinder the impact of WtUKP on the individuals practice. The majority of doctors did have this motivation and readiness to learn, enhanced further by attendance at WtUKP. Post WtUKP, some participants reported that they were now more aware of what they did not know and as a result wanted to find out more information and attend more courses.

“The workshop really helped me realise how much behind I was... I needed to work on this and from that point forward I really improved and had no problems at all. It’s been a smooth ride after that”. (Attendee 19_male)

“It really also depends on whether the doctor wants to learn, do they want to change practice.” (Supervisor 1_Male)

Others at follow up had signed up to or had already attended further training.

“I attended a few more workshops after that workshop put in my mind that I should attend more. I attended more workshops like breaking the bad news, and these few things after...I could now call for chaperones, now I make sure I do proper documentation, from recommendations and I think everything was

more focused on communication in this workshop...but definitely triggered motivation to attend more workshops after this". (Attendee 3_male]

4.7 Marketing, expectations, attendance and expansion

4.7.1 Awareness of the WtUKP workshops and online tools

Most overseas doctors who attended WtUKP became aware of the workshop whilst registering with the GMC (via email). During interviews and focus groups, participants reported that they thought this was the best way to make overseas doctors aware of WtUKP. The website and social media platforms were also useful channels.

"Well I think I got a leaflet while registering at GMC and it's the best way I think because you are going to get to the people who are starting in the UK and their practice. So, I think it's the best way to advertise and of course social media. Website or Facebook or twitter or any other". (Attendee 14_female)

Only 13% of attendees and non-attendees reported they had accessed the WtUKP online tool. The main reason for this was that many of the doctors were simply not aware of it. Others had not had the time to access the tool, or were yet to come across a scenario where they have needed to use it. However, the few that had used the tool reported that it was useful. The importance of accessing other GMC online materials, including the App, were highlighted by the small number of doctors who had accessed them.

"I've done the online training thing with the ethical dilemmas. I think many of the issues that I encountered were probably more Trust specific and it probably would be difficult to cover on WtUKP. But I think it was a really good selection of topics. (Attendee 4_male)

"The eBooks which are available on the GMC website I downloaded them, and I keep them near my phone so whenever I have to go through them I have them." (Attendee 5_male)

"I have especially the GMC App on my phone and I've been using it especially in the first one month, I am using it every day but now I am getting on OK, I am a little bit less on it. But it's like a guiding light in the background if ever I am caught up with something" (Attendee 10_male)

Many of the doctors commented that they would access the online tool/App now they had been made aware of it during the WtUKP workshop.

"We've got the App, that is very important for us because we can't bring all this stuff [guideline booklets] but knowing that there is an App, and also the answers on line course [toolkit], but the App I think is one of the most...I discovered it today" (Focus Group London, L/15)

"Is this a new online course? I haven't come across any online courses. That would be easier for me to attend. OK I will do that then. I will definitely go for that" (Non-attendee 13_female)

Improved promotion of WtUKP would likely facilitate uptake. Supervisors were largely unaware of WtUKP, but expressed that now they were, they would be keen to encourage and advise their overseas trainees to attend WtUKP and access the online resources. Only two attendees said that they had become aware of the workshop via a senior, whilst few mentioned awareness through colleagues.

"Does the GMC have anything on their website? How do you make them aware of it? I didn't know before speaking from you any of this even existed. I think it needs to be publicised somehow". (Supervisor 3_male)

It was further suggested by supervisors that Royal Colleges and Health Education England (HEE) should play a role in reinforcing attendance. It was felt that the importance of attending WtUKP should be stressed to both overseas doctors and their employing organisations. Supervisors commented that raising awareness about WtUKP and the content covered within it would help them to support the doctors' learning in practice.

4.7.2 *The doctors that failed to attend WtUKP*

The attrition rate for attendance at WtUKP (the number of doctors at each workshop who signed up but did not attend) was high during this evaluation (33% at national workshops and 43% at local workshops). All but one workshop suffered some attrition. Of the non-attendee group, 64% were unable to attend due to not being able to get time off work. Many of the doctors who attended WtUKP, but were already in practice, benefited from WtUKP being run on a Saturday. Attendees, non-attendees and the RLAs felt that more weekend/evening and local workshops would likely facilitate higher attendance.

“It was good that it was organised when we were not working on the weekend, so I could attend easily”
(Attendee 17_male)

“I think we need to resource that internally to deliver this more and more and we need to look at doing evenings and weekends because that seems to be what the feedback tells us.” (RLA 2_female)

The majority of non-attendees (85%) reported that they planned to attend another WtUKP. Two doctors had already attended another WtUKP workshop at the time of interview. However, many doctors again mentioned the difficulty of getting time out from practise to attend later.

Other reasons for not attending included bad weather; being unable to get childcare (70% were married and 57% had dependants); and difficulties travelling to the locations offered. There were also doctors who were not yet working in the UK and having booked a place were then not in the country to attend the course.

However, some doctors had reconsidered the relevance of the course for their needs. Some maintained they did not need it, as looking at the GMC website was enough for them. Others decided not to attend, as they perceived the course was targeted at those newer to UK practice than themselves.

4.7.3 *Meeting expectations*

It was evident in all datasets that doctors were not always clear about what to expect from the workshops. Although some of the expectations did align with WtUKP content, a number of areas attendees expected to be covered were not. These included: registration and obtaining a post, knowledge about the NHS, it's structure and hierarchy, medical roles and responsibilities, career guidance, appraisal and revalidation, legal protection, patient expectations, and cultural differences (discussed further below).

Attendees, RLA's and the majority of supervisors reported that an overview of the day's content and what to expect would have been useful prior to them attending WtUKP. This highlighted that doctors were not always clear about what to expect from the workshops. Doctors often stated they expected that WtUKP would be focussed on how to get GMC registration or find a post. Better communication about the content of WtUKP is needed.

“I think that is really important for someone who doesn't know what's going to happen in this course he might not turn up thinking it's not necessary but if they know that XYZ is going to be covered they might actually make time to attend the course keeping in mind it covers important topics”. (Attendee 10_male)

WtUKP is aimed at doctors who are new to the UK, whether they are in practice yet or not. However, some non-attendees reported that they did not think the workshop was relevant for them now that they were in practice. This was likely because they were not fully aware of the content, particularly as the name suggests the workshop is for those completely new to the UK.

“I think in some ways the title doesn't always say what it means on the tin if you like, I think we struggle locally with that idea that people think they are not in that welcome phase they are in the doing phase and I think some people will not understand the benefit of attending” (RLA 11_male)

4.7.4 Incentivising or mandating WtUKP

Many agreed that the GMC should explore incentivising doctors to attend WtUKP. One approach to this may be awarding CPD points for attending the workshops. Some participants felt that this would encourage attendance. However, others thought that this was unlikely to incentivise doctors new to the UK to attend, as they rarely knew about CPD points.

“It would be beneficial and would attract more people to attend WtUKP if attendance would grant CPD points”. (Follow-up attendee free text questionnaire)

“I’m not so sure they are new doctors they don’t really even understand it, they don’t even understand revalidation let alone CPD points. So, I personally don’t think it will make a massive difference”. (RLA 1_female)

Ultimately, all groups that were consulted said that they would be supportive of WtUKP being made mandatory for all doctors new to UK practice.

“I mean the GMC one should be mandatory. People don’t know about it and it shouldn’t be optional. If we think, it is going to make them better doctors and more successful, then they should do it...It should be mandatory. You can come with a full set of medical skills but have no cultural or softer skills. Everybody is at different levels, but everybody will take something out of it”. (Supervisor 16_female)

“It is for our safety [the workshop] to make it compulsory”. (Focus Group London, L/20)

4.7.5 When is the ideal time for doctors to attend WtUKP?

Most of the study participants reported that having the opportunity to attend WtUKP prior to starting practice in the UK was the optimum time to attend. It would support overseas doctors to understand what is required of them before starting work, and to help mitigate issues that may occur during practice.

“It’s quite good to have it before I started. To see if I was aware of some of the regulations, some of the things that could be different, and I think it could be quite frustrating to do anything wrong for the first time and then learn again afterwards...Two, to three months should be a good time” (Attendee 4_male)

“Ideally before practice, it is saying how to do things properly, enabling and encouraging the doctors to work”. (Supervisor 16_female)

Some doctors reported that they had already started working before they had attended WtUKP, but until they had attended the workshop they were not fully aware of some of the challenges and differences in UK practice, and that WtUKP had increased their awareness. For others, the half-day served as a refresher and enabled them to reflect on their current practice. Some doctors commented that they wished that they had attended the workshop before starting work as it would have made their transition easier. In terms of making it easier for overseas doctors to attend, participants suggested including WtUKP as part of the day when they attend their ID check.

4.7.6 Suggested additional content, expansion and follow-up

In addition to what is currently covered; there were several areas that attendees, RLAs and supervisors suggested could also be beneficial to cover through WtUKP. Specific content suggested included:

- More information about NHS systems, for example NHS hierarchy/structure, patient referrals, multi-disciplinary team working, and staff roles/responsibilities.

“We know the medical stuff but regarding the structure and where you are working and what they expect from us, that is an important thing which I think could have been dealt with a little bit more”. (Attendee 10_ male)

“I expected there to be some information about the NHS. Like maybe more logistical or practical things, differences between practices...referrals, logistics” (Focus Group London, L/20)

“There is an issue of maintaining boundaries, professional boundaries which we haven’t got in the course at the minute and if you look at the FTP cases that are coming through with IMG doctors associated with them, a lot are about inappropriate work relationships, either with colleagues or patients.” (RLA 11_ male).

- More advice and guidance on career progression and pathways, CPD and e-portfolios.

“Another thing I think might also be good is if you can incorporate that into something like career guidance. Let medical practitioners know the various career options that the medical doctors in the country I think that would also help many people who come in blindly really, blindly looking for, I know you get a lot of conflicting information, so something like career guidance, I’m sure just this one area, everything else was really nice”. (Attendee 1_ male)

- More scenarios and interactive case studies about doctors who have experienced similar difficulties and challenges. Additionally it was suggested these should include appraisal and revalidation, legal issues, professional boundaries, under 18s, the use of chaperones and consent with regard to communicable diseases.

“If I was to content summarise I would say a bit more scenarios because that was probably the last time that someone mentioned those things about consent and mental capacity, a few more different scenarios to highlight all the things. Maybe spend a bit more time on that, that would have helped.” (Attendee 13_ male)

- More advice on where to find other information to support the transition was also requested; such as dealing with negative behaviours and conflict, indemnity insurance and occupational health procedures (although it is recognised that this may be more specific for each Trust).

“I think they covered a lot the GMC, but I went there to find out how to safeguard myself from the establishment where I am in, because I think when it comes to my first review and you don’t know. It’s all about patient care, patient consent but at the same time maybe the doctor may be in danger... That thing [learning about safeguarding yourself] should have been done here, make sure you get occupational health done, make sure you get this, make sure you get that.... This [should be] done before you start your work not just go and report and start your work.” (Attendee 20_ female)

- An experienced overseas doctor in attendance at WtUKP to provide helpful advice about what lay ahead and offer support.

“I think it should reflect more on the mistakes done by new doctors to the UK system & tips on how to avoid or deal with those mistakes if done”. (Attendee post questionnaire free text comments)

“Talks delivered by IMGs giving their personal account of what helped them get through. This would greatly benefit us.” (Attendee post questionnaire free text comments)

It was recognised by participants that it would not be possible for all of this to be included within the current half-day workshop. Some felt more time was needed in the workshop to cover additional content, possibly by extending WtUKP to a full day.

“I strongly do feel it should be a little bit longer, a lot of the feedback tends to suggest that.” (RLA 3_ male)

Many identified the need for some form of follow-up to WtUKP two to three months after attending; this follow-up could have more emphasis on being in practice.

“The best thing is to attend it at the start as well as once you start the practice. I think there should be a refresher to see if there are any difficulties after having the actual experience of working in the GMC

environment, then you may be able to come up with some new questions and that will definitely improve your knowledge as well as to help you a lot". (Attendee 5_male)

"I think it would be the ideal (workshop in two parts) wouldn't it because we could do follow up interviews with them and pick up real-life issues that are happening for them at work and then adapt the program from those things. So, there is so many positives from that, that we could expand it even more and make it more relevant because we'd be listening to their real needs". (RLA1, Female)

5 Discussion

The broad aims of this evaluation were to: a) develop an evidence base on the short and long-term impact of WtUKP on participants and their practice, and b) identify ways of improving the content and delivery of WtUKP offline and online.

Short-term impact

We have identified that WtUKP is highly valued by overseas-qualified doctors and their supervisors. Our evaluation indicates that doctors' awareness and understanding of UK practice, professional standards and GMC guidance significantly improved after attending WtUKP. Significant improvement in the validated scales, assessing patient centeredness and communication self-efficacy suggest that doctors are more aware of the need to be caring and compassionate, understand how to communicate and facilitate shared decision making with patients. In addition, WtUKP provides attendees' with the opportunity to meet other doctors in the same position, offering them scope to learn from each other and gain additional support.

Long-term impact

The short-term impacts were sustained in a number of areas at the three-month follow-up stage, particularly in the validated scales assessing patient centeredness and communication self-efficacy. These findings might further translate into practice, since the qualitative data suggests that doctors had more understanding about adapting to the UK culture of seeing the patient as a partner in the options for treatment rather than deciding for the patient in an autocratic manner. This may manifest as asking the patient about their ideas, concerns and expectations and listening more to the views and preferences of patients. Increased confidence in communicating to both patients and colleagues in practice is also suggested. Previous research illustrated a similar short-term impact in these areas, evidencing that doctors experienced less complaints and performance issues, were more compassionate doctors, maintained increased communication skills and had more ethical awareness in practice (Kehoe, 2017).

However, decay was evident in some areas concerning perceived knowledge of NHS practice and culture, quite surprisingly (given the evidence highlighted above) this was significantly evident in the area concerning being open and honest with patients. Yet this is understandable given that this is still being introduced into the UK and most doctors reported that this was not a practice in their own country. Furthermore, if doctors do not feel supported in practice (as the evidence suggests may be the case), they may not feel able to admit mistakes. There was also a significant drop in attendees' understanding of the role of the GMC and how to apply GMC guidance. Doctors further reported feeling less supported by the GMC. This was the same for doctors in practice, which suggests that what they learnt in the workshop may not be being reinforced in practice. Yet despite some decay, improvement in scores compared to baseline was evident, particularly around applying GMC guidance.

Greater use of the learning log may further encourage reflection in practice and ensure that those who have the intention to change their practice are able to do so. Given that these doctors are new to the concept of a portfolio and workplace-based assessment, they are more likely to experience difficulty progressing through their training (including the Annual Review of Competency Progression; Rothwell, 2017).

Improved perception of GMC

Whilst there were mixed views on the GMC, overall doctors reported that attending WtUKP had improved their perceptions of the GMC, particularly valuing the positive engagement with the GMC staff delivering WtUKP. This

was further supported by observations from RLAs. Those doctors who felt their view had not changed about the GMC, reported seeing the GMC as more regulatory than supportive, often referring to previous negative experiences.

Is WtUKP more or less effective for different groups of doctors?

All doctors benefited from WtUKP. Similar improvements were demonstrated for both EEA and IMG doctors. However, IMG doctors often had more prior awareness about the content of WtUKP, possibly reflecting earlier experiences from studying for PLAB exams.

As reported, doctors in practice reported scores similar to doctors not in practice for the majority of measures. At follow up, doctors in practice also reported a significant drop in their understanding of how to apply GMC guidance. The analysis of non-attendeo data (74% were in practice) further illustrated less awareness and understanding in all areas tested. Again, this could highlight that GMC guidance is not reinforced in practice and supervisors need to provide further reinforcement. However, it could also be that doctors who are not yet in practice are less realistic about their learning needs.

The importance of a positive learning environment in practice

The evidence from this evaluation has highlighted a general lack of support for overseas doctors when they are in practice (particularly reported by supervisors we spoke to). The majority of supervisors were unaware of WtUKP and unsurprisingly none of them knew that their supervisees had attended. Supervisors also felt that they were to some extent unaware of the specific needs of overseas doctors, and therefore were not in the position to facilitate further learning.

Supervisors generally recognised that overseas-qualified doctors needed support from their colleagues, but this was not always provided. Indeed, they often observed a lack of understanding, intolerance and bullying. Negative experiences, including undermining and racism, were also highlighted by the overseas doctors themselves. Many of them reported feeling isolation, loneliness and a lack of peer support.

Despite an initial boost in confidence following WtUKP, it was common for the doctors in this evaluation to lack the confidence to ask questions, raise concerns, and challenge senior colleagues when required. This could also be reflective of a negative learning environment. Hofstede's (2011) offers a model to help interpret these cultural differences. For example, 'power distance' which is small in the UK, is large in certain cultures (such as India), and these cultures place greater emphasis on hierarchy. These employees are more reluctant to disagree with seniors and seniors in these cultures are more likely to chastise juniors. This reinforces their hesitancy to ask questions or seek help leaving them more exposed to mistakes. Doctors from 'collectivists' cultures (who are more likely to place group needs above individual needs and may be less likely to speak up; Morrow *et al.*, 2013).

Supervisors evidently need to become more aware about the need to support overseas doctors and ensure they are working in a positive learning environment. Some supervisors reported being out of their depth and felt that they needed more guidance and support, particularly concerning sensitive areas such as bullying and racism. Developing a network of supervisors in each area across the UK may help to support this.

It is important for the GMC to inform Trusts, supervisors and employing organisations that they all have a major role to play in supporting these doctors. The GMC could seek to engage with employers (education and HR departments) to provide information and guidance on how best to support these doctors. For example, suggesting peer buddy and peer support be developed.

Previous research in this area highlights the complexity of supporting overseas-qualified doctors. WtUKP provides an important training intervention, which is only part of the necessary support system needed to ensure a successful transition to the UK. The individual also needs to be motivated and have the desire to acquire the necessary skills and knowledge. The organisation must further facilitate a supportive culture and provide a supportive work environment. These three components work together, either positively to drive a successful transition, or negatively to create resistance (Kehoe, 2016; Kehoe, 2017). The figure below (figure 2) illustrates that the central cog (training, i.e. WtUKP) is key to linking the organisation with the individual. Using the cogs, one can understand how an individual, who is highly motivated, can work in a system and organisation that is

unsupportive, but the effort required is very high. In contrast, a supportive organisation creates positive energy, supporting the training intervention and the doctor, so the effort required is lower.



Figure 2. Key components to facilitate successful transition of overseas-qualified doctors (Kehoe *et al.*, 2016)

Facilitating access to WtUKP

The findings in this report have suggested several ways to help increase attendance, hopefully supporting the GMC's current target of reaching 80% of overseas-qualified doctors. WtUKP should be delivered locally, nationally and flexibly (including delivery at weekends). Attendance could be further increased by promoting the workshops through supervisors of overseas-qualified doctors, who felt that they could also promote use of the online tool (the majority of doctors were unaware of this).

The analysis on non-attendees highlighted that this group had more difficulty attending WtUKP due to employment and family commitments. This highlights the necessity for flexible delivery of WtUKP e.g. weekend and local workshops. It was also suggested that providing WtUKP to coincide with ID checks would promote attendance before practice (which is the ideal time to prevent difficulty in practice). Offering incentives such as CPD points may be another possibility to improve attendance.

Ultimately, the majority of study participants highlighted the importance of ensuring all overseas doctors attend WtUKP. They recommended that the workshops should be made mandatory, viewing this as a positive step forward.

Expansion and follow up

There was unanimous support for expanding WtUKP to allow more time to cover complex areas that attendees did not understand well, such as communicable diseases, and more time for networking. Attendees also highlighted that there were some unmet needs (e.g. support to find a job and GMC registration), which in part may be due to not being made fully aware of the focus of WtUKP before attending. Many overseas doctors understood WtUKP to be targeted at those completely new to the UK.

Evidence from this evaluation indicates that ideally there should be follow up on what was learned in WtUKP once doctors have spent more time in practice. This will reinforce what was learnt and provide an opportunity for real issues from practice to be shared, discussed and clarified. This follow up could be achieved in various ways, e.g.:

- Encouraging doctors and their supervisors to make use of the log book
- Promoting the existing WtUKP online tool or developing some other form of e-learning
- Engaging with other GMC support programmes like *Duties of a Doctor*
- Delivering a bespoke second WtUKP follow-up workshop

Caution needs to be taken when thinking about online implementation, given that engagement with WtUKP online tools was found to be poor. All attendees highly valued the face to face interaction with both their colleagues and RLAs, it providing them with a necessary platform for discussion and networking.

5.1 Limitations

Doctors may not be aware of their learning needs, particularly those that are not yet in practice. Those from a more 'masculine' societies (Hofstede, 2011) may be more likely to over-rate their own performance. As WtUKP is targeted at doctors new to practice, we were more reliant on self-report measures. We know from research that self-report can be unreliable (Colthart *et al.*, 2008). For example, it is possible that the overseas doctors have over-assessed their competence and without an objective measure we cannot assess this reliably. However, the vignettes did attempt to objectively assess the knowledge gained during WtUKP. The validated scales were also a strong indicator of change. In addition, we attempted to obtain objective perceptions of performance from supervisors, to triangulate the data. However, because the supervisors were unaware that their supervisee had attended WtUKP, they were unable to comment on any specific change in their practice.

Ideally, a longer evaluation period, for example twelve months, could have included educational governance data to link outcomes following WtUKP. Previous research from this group included objective measures and was able to illustrate benefit over a twelve-month period (Kehoe, 2017). Future research could include educational outcome measures, such as complaints and serious untoward incidents, which can be linked back to individuals. Fitness to practise data can also be explored, however these are few and more extreme, and there are many other variables that are likely to impact on this. It would also be useful to explore other measures such as retention.

The study design also meant that the non-attendee group could not be used as a control group as we were only able to collect data at a single time point (at three month follow up). However, it was useful to consult with this group to explore any differences to the attendee group, particularly qualitatively.

Our analysis has focused on doctors who have attended or planned to attend WtUKP. However, there is another group not included; those who did not sign up and do not plan to attend. Currently, we have no data about these doctors on how and if they differ, and if they pose more of a risk for patient safety as they may assume they do not require WtUKP.

It is important to note that this evaluation coincided with the very public case of a doctor who was found guilty of manslaughter and was subsequently removed from the GMC register. This may have impacted on doctors' perception of the GMC during the evaluation period.

As all the researchers were female and from the UK this may have influenced what was reported by the male participants. For example, participants from 'masculine' societies may have more hesitation reporting areas they perceive to be weak to female interviewers (Hofstede, 2011).

6 Conclusion

Overall, attendees reported the value of attending WtUKP and interacting with both colleagues and the GMC face to face; feeling it set them on the right path to good medical practice in the UK and alerted them to their learning needs. Attendees' knowledge about key areas of GMC guidance improved following WtUKP. Attendees also reported an increased awareness and understanding about UK practice. There was mixed evidence to indicate that WtUKP had a positive impact on perceptions of the GMC.

However, at the three-month follow up, there was some reported decay, particularly in understanding about GMC guidance, highlighting the importance of reinforcement in practice. WtUKP is a proactive, preventative measure to support a successful transition to the NHS. However, we know from other research that in addition to this targeted training, doctors also need to work and train in a positive, supportive learning environment. The GMC could play a major role in highlighting this to employers. A number of recommendations for developing the content and delivery of WtUKP have been identified and presented to the GMC.

The GMC are ultimately sending a very important message to the medical community through delivery of WtUKP, highlighting that these doctors need additional input to adjust their practice and meet the requirements of

medical practice in the UK. This proactive and preventative action from the GMC is the start of supporting a successful transition to the NHS.

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Appendix 1. Pre-WtUKP questionnaire

Welcome to UK Practice (WtUKP) evaluation

Please complete this questionnaire **before** the WtUKP workshop starts and return it to the researcher present.

Individual responses will remain wholly **confidential**. All data will be anonymised and no identifiable data will be reported or shared with the GMC.

This questionnaire aims to identify your views before you take part in the WtUKP workshop and will help us to identify how best to help doctors from overseas in practice.

This is a baseline questionnaire and we plan to repeat the questionnaire in the future. So that we can link your questionnaires, please enter the last 4 digits of your GMC Unique ID:

1) **Code:** _ _ _ _
(Last 4 digits of your GMC UID)

A. Practice in the UK

How much do you agree with the following statements? (please tick)	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Neither Agree nor Disagree ⁴	Somewhat Agree ⁵	Agree ⁶	Strongly Agree ⁷
2. I <i>am aware</i> I will need to adjust my practice to fit the UK medical system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I <i>am aware</i> of the challenges I may face practising medicine in the UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I <i>understand</i> the role of the GMC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I <i>do not feel able</i> to deal with cultural differences that I may face in practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I <i>do not understand</i> the structure and hierarchy of the NHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I <i>am comfortable</i> working as part of a multidisciplinary team <i>i.e. working in a team with other doctors, nurses, health care assistants etc.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I <i>am comfortable</i> asking others for help if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I <i>understand</i> how to communicate with patients' relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I <i>am not aware</i> of how to challenge poor behaviour of a senior colleague	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I <i>am aware</i> of the need to be open and honest with patients following an error or mistake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I feel the GMC <i>are</i> supportive of doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Are you <i>aware</i> of GMC guidance for doctors (for example Good Medical Practice, Consent, Confidentiality and other guidance)	Yes ¹ <input type="checkbox"/>	No ² <input type="checkbox"/>					
If NO , go to Q18							
How much do you agree with the following statements? (please tick)	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Neither Agree nor Disagree ⁴	Somewhat Agree ⁵	Agree ⁶	Strongly Agree ⁷
14. When I have a professional dilemma, I <i>will</i> consult GMC guidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I <i>understand</i> how to apply GMC guidance on consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I <i>understand</i> how to apply GMC guidance on confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I <i>understand</i> how to apply GMC guidance on how to raise a patient safety concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Your views on patients

The list below shows 18 statements concerning the patient-doctor relationship within the NHS.
Please indicate to which extent you agree with each of the following statements (please tick).

	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Somewhat Agree ⁴	Agree ⁵	Strongly Agree ⁶
18. The doctor is the one who should decide what is talked about during a consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Although health care is less personal these days, this is a small price to pay for medical advance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. The most important part of the standard medical visit is the physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. It is often best for patients if they do not have a full explanation of their medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Patients should rely on their doctors' knowledge and not try to find out about their conditions on their own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. When doctors ask a lot of questions about a patient's background, they are prying too much into personal matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. If doctors are truly good at diagnosis and treatment, the way they relate to patients is not that important	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Many patients continue asking questions even though they are not learning anything new	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Patients should be treated as if they were partners with the doctor, equal in power and status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Patients generally want reassurance rather than information about their health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. If a doctor's primary skills are being open and warm, the doctor will not have a great deal of success	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. When patients disagree with their doctor, this is a sign that the doctor does not have the patient's respect and trust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. A treatment plan cannot succeed if it is in conflict with a patient's lifestyle or values	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Most patients want to get in and out of the doctor's office as quickly as possible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. The patient must always be aware that the doctor is in charge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. It is not that important to know a patient's culture and background in order to treat the person's illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Humour is a major ingredient in the doctor's treatment of the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. When patients look up medical information on their own, this usually confuses more than it helps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Communication Skills

Below is a list of tasks that you may face when practising. Please indicate how certain you are that you can successfully perform each of the following tasks (*please circle*).

1 = Very uncertain

5 = Very certain

36. Initiate a conversation with a patient regarding his/her worries	1	2	3	4	5
37. Conclude a consultation with a summary of the problems and a treatment plan	1	2	3	4	5
38. Assess symptoms of anxiety and depression	1	2	3	4	5
39. Communicate bad news to a patient	1	2	3	4	5
40. Confront in an appropriate manner a patient who denies his/her illness	1	2	3	4	5
41. Cope with a situation in which a patient or a relative expresses disagreement with you as a doctor	1	2	3	4	5
42. Encourage a patient to describe his/her feelings	1	2	3	4	5
43. Explore intense emotions, such as anger, in a patient	1	2	3	4	5
44. Help a patient cope with an uncertain situation	1	2	3	4	5

D. Demographics

45. What nationality are you?

46. Country of primary medical qualification?

47. How long ago did you obtain your primary qualification? **Years**..... **Months**.....

48. How many years of postgraduate medical training have you had, if any? **Years**..... **Months**.....

49. Date of registration with the GMC?

50. Are you currently living in the UK? YES ¹ / NO ² (<i>please circle</i>)	
If YES please answer Q51 to Q54 BELOW and then move to Q56	If NO please answer Q55 BELOW and then move to Q56
51. How long have you been living in the UK? Years Months	55. What country are you currently living in?
52. Where in the UK are you currently living?	
53. What was the last country you were practising in before moving to the UK?	
54. What best describes your last job role before moving to the UK?	

56. Are you currently practising medicine? YES¹ / NO² (please circle)	
If YES please answer Q57 to Q59 BELOW and then move to Q61	If NO please answer Q60 BELOW and then move to Q61
57. Where do you currently work?	60. How long has it been since you practised medicine? Years..... Months.....
58. What best describes your current job role?	
59. How long have you been in this role? Years..... Months.....	

61. Which specialty do you intend to work in?

62. Are you...? <input type="checkbox"/> Male ¹ <input type="checkbox"/> Female ² <input type="checkbox"/> Do not wish to disclose ³	63. What is your age? <input type="checkbox"/> 18-24 ¹ <input type="checkbox"/> 25-34 ² <input type="checkbox"/> 35-44 ³ <input type="checkbox"/> 45-54 ⁴ <input type="checkbox"/> 55 or over ⁵ <input type="checkbox"/> Do not wish to disclose ⁶
64. What is your marital status? <input type="checkbox"/> Single ¹ <input type="checkbox"/> Married ² <input type="checkbox"/> Cohabiting ³ <input type="checkbox"/> Divorced ⁴ <input type="checkbox"/> Widowed ⁵ <input type="checkbox"/> Other ⁶ <input type="checkbox"/> Do not wish to disclose ⁷	
65. Do you have dependents? (e.g. children): <input type="checkbox"/> Yes ¹ <input type="checkbox"/> No ² <input type="checkbox"/> Do not wish to disclose ³	
66. In which ethnic group do you classify yourself?	
White <input type="checkbox"/> British ¹ <input type="checkbox"/> Irish ² <input type="checkbox"/> Any other white background ³ <input type="checkbox"/> Do not wish to disclose ¹⁷	Mixed <input type="checkbox"/> White & Black African ⁴ <input type="checkbox"/> White & Black Caribbean ⁵ <input type="checkbox"/> White & Asian ⁶ <input type="checkbox"/> Any other mixed background ⁷
Asian <input type="checkbox"/> Indian ⁸ <input type="checkbox"/> Pakistani ⁹ <input type="checkbox"/> Bangladeshi ¹⁰ <input type="checkbox"/> Chinese ¹¹ <input type="checkbox"/> Any other Asian background ¹²	Black <input type="checkbox"/> Caribbean ¹³ <input type="checkbox"/> African ¹⁴ <input type="checkbox"/> Any other black background ¹⁵ <input type="checkbox"/> Arab ¹⁶

67. What is your religion?

- | | | |
|---|--|---|
| <input type="checkbox"/> Christian ¹ | <input type="checkbox"/> Sikh ⁵ | <input type="checkbox"/> Do not wish to disclose ⁹ |
| <input type="checkbox"/> Muslim ² | <input type="checkbox"/> Jewish ⁶ | |
| <input type="checkbox"/> Buddhist ³ | <input type="checkbox"/> Other ⁷ (Please state) | |
| <input type="checkbox"/> Hindu ⁴ | <input type="checkbox"/> None ⁸ | |

68. What are your expectations from attending this WtUKP workshop?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

If you have any questions, please contact Amelia Kehoe (amelia.kehoe@newcastle.ac.uk)

Appendix 2. Post-WtUKP questionnaire

Welcome to UK Practice (WtUKP) evaluation

Please complete this questionnaire **after attending** the WtUKP workshop and return it to the researcher present.

Individual responses will remain wholly **confidential**. All data will be anonymised and no identifiable data will be reported or shared with the GMC.

This questionnaire aims to identify your views after you have taken part in the WtUKP workshop and will help us to identify how best to help doctors from overseas in practice.

This is the second of three questionnaires. So that we can link your questionnaires, please enter the last 4 digits of your GMC Unique ID:

1.

Code: _ _ _ _

(Last 4 digits of your GMC UID)

A. Practice in the UK

How much do you agree with the following statements? (please tick)	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Neither Agree nor Disagree ⁴	Somewhat Agree ⁵	Agree ⁶	Strongly Agree ⁷
2. I <i>am aware</i> I will need to adjust my practice to fit the UK medical system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I <i>am aware</i> of the challenges I may face practising medicine in the UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I <i>understand</i> the role of the GMC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I <i>do not feel able</i> to deal with cultural differences that I may face in practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I <i>do not understand</i> the structure and hierarchy of the NHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I <i>am comfortable</i> working as part of a multidisciplinary team <i>i.e. working in a team with other doctors, nurses, health care assistants etc.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I <i>am comfortable</i> asking others for help if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I <i>understand</i> how to communicate with patients' relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I <i>am not aware</i> of how to challenge poor behaviour of a senior colleague	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I <i>am aware</i> of the need to be open and honest with patients following an error or mistake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I feel the GMC <i>are</i> supportive of doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Are you <i>aware</i> of GMC guidance for doctors (for example Good Medical Practice, Consent, Confidentiality and other guidance)	Yes ¹ <input type="checkbox"/>	No ² <input type="checkbox"/>
---	--	---

If **NO**, go to **Q18**

How much do you agree with the following statements? (please tick)	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Neither Agree nor Disagree ⁴	Somewhat Agree ⁵	Agree ⁶	Strongly Agree ⁷
14. When I have a professional dilemma, I <i>will</i> consult GMC guidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I <i>understand</i> how to apply GMC guidance on consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I <i>understand</i> how to apply GMC guidance on confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I <i>understand</i> how to apply GMC guidance on how to raise a patient safety concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Your views on patients

The list below shows 18 statements concerning the patient-doctor relationship within the NHS.
Please indicate to which extent you agree with each of the following statements (please tick).

	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Somewhat Agree ⁴	Agree ⁵	Strongly Agree ⁶
18. The doctor is the one who should decide what is talked about during a consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Although health care is less personal these days, this is a small price to pay for medical advance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. The most important part of the standard medical visit is the physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. It is often best for patients if they do not have a full explanation of their medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Patients should rely on their doctors' knowledge and not try to find out about their conditions on their own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. When doctors ask a lot of questions about a patient's background, they are prying too much into personal matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. If doctors are truly good at diagnosis and treatment, the way they relate to patients is not that important	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Many patients continue asking questions even though they are not learning anything new	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Patients should be treated as if they were partners with the doctor, equal in power and status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Patients generally want reassurance rather than information about their health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. If a doctor's primary skills are being open and warm, the doctor will not have a great deal of success	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. When patients disagree with their doctor, this is a sign that the doctor does not have the patient's respect and trust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. A treatment plan cannot succeed if it is in conflict with a patient's lifestyle or values	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Most patients want to get in and out of the doctor's office as quickly as possible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. The patient must always be aware that the doctor is in charge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. It is not that important to know a patient's culture and background in order to treat the person's illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Humour is a major ingredient in the doctor's treatment of the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. When patients look up medical information on their own, this usually confuses more than it helps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Communication Skills

Below is a list of tasks that you may face when practising. Please indicate how certain you are that you can successfully perform each of the following tasks (*please circle*).

1 = Very uncertain

5 = Very certain

36. Initiate a conversation with a patient regarding his/her worries	1	2	3	4	5
37. Conclude a consultation with a summary of the problems and a treatment plan	1	2	3	4	5
38. Assess symptoms of anxiety and depression	1	2	3	4	5
39. Communicate bad news to a patient	1	2	3	4	5
40. Confront in an appropriate manner a patient who denies his/her illness	1	2	3	4	5
41. Cope with a situation in which a patient or a relative expresses disagreement with you as a doctor	1	2	3	4	5
42. Encourage a patient to describe his/her feelings	1	2	3	4	5
43. Explore intense emotions, such as anger, in a patient	1	2	3	4	5
44. Help a patient cope with an uncertain situation	1	2	3	4	5

D. Feedback on Welcome to UK Practice (WtUKP)

45. What aspects of the WtUKP session were most useful? State your top **three**:

1.

2.

3.

46. Do you intend to change your practice as a result of attending WtUKP? **YES**¹ / **NO**² (*please circle*)

If **YES**, how do you intend to change your practice? If **NO**, why not?

47. Have you accessed the WtUKP **self-assessment online tool** before attending this session? **YES**¹ / **NO**²
(please circle)

If **YES**, how useful was this online tool? If **NO**, what is the reason for not accessing it?

48. How could we improve WtUKP in the future? (*Missing content, delivery etc.*)

49. Overall how would you rate today's WtUKP workshop? (*please circle*)

Very good¹ / **Good**² / **Neither good nor poor**³ / **Poor**⁴ / **Very poor**⁵

50. Would you recommend this workshop to a colleague? (*please circle*)

YES¹ / **NO**²

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

If you have any questions, please contact Amelia Kehoe (amelia.kehoe@newcastle.ac.uk)

Appendix 3. Pre and post vignettes to assess knowledge of GMC guidance (including answers)

1. Mr Jacobs is 80 years old. He was diagnosed about a year ago as being in the early stages of Alzheimer's. He lives independently but his condition has begun to deteriorate in the last few months, and his daughter, Mary, is concerned about his future care. Mr Jacobs has come to see his GP, Dr Taylor, with his daughter. He has been suffering with stomach pain for many weeks which has now worsened. Dr Taylor has carried out a physical examination.

Dr Taylor: I think we're going to need to refer you for further investigation. How have you been coping since our last appointment?

Mr Jacobs: I don't want to go into hospital...

Mary: He's in a lot of pain, aren't you, Dad? He's hardly sleeping which isn't helping his state of mind.

Dr Taylor: Well we can have a look at your medication and see if there's anything more we can do for the pain. In the circumstances I think it would be best if I refer you for an ultrasound scan.

Mr Jacobs: I don't want to go into hospital!

Mary: But we've got to find out what's wrong. We'll have the referral please.

Dr Taylor: It's a very simple investigation, Mr Jacobs: you should be in and out in a couple of hours.

Mr Jacobs: The pain's not too bad. It'll go...

Mary: Oh Dad you know that's not true! You didn't sleep at all last night. You just don't remember. Make the referral please doctor. I'll make sure he goes.

What should the doctor do next...? (Circle A, B or C)

A: Refer Mr Jacobs for the ultrasound scan with his daughter's consent?

B: Politely ask Mary to leave the consulting room so that he can talk to Mr Jacobs alone to establish what his wishes might be, and whether he has capacity to consent to the referral?

C: Decide on the basis of this consultation so far that Mr Jacobs - because of his Alzheimer's - does not have capacity to give consent for the referral and refer him for the ultrasound scan because it would be in his best interest?

See what the doctor did

Dr Taylor politely explains to Mary that he really needs to hear from her father himself about what he wants. Mr Jacobs is initially a little confused about what is proposed, and upset about the idea of going to hospital. However, Dr Taylor decides that - with some extra support - Mr Jacobs does have capacity to decide whether or not to have the ultrasound scan, and manages to persuade him that it would be in his best interests. Mr Jacobs agrees to the referral.

References

64. You must work on the presumption that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment. You must only regard a patient as lacking capacity once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision, or communicate their wishes.

65. You must not assume that a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), their beliefs, their apparent inability to communicate, or the fact that they make a decision that you disagree with.

(Consent: patients and doctors making decisions together, paragraphs 64-65)

66. A patient's ability to make decisions may depend on the nature and severity of their condition, or the difficulty or complexity of the decision. Some patients will always be able to make simple decisions, but may have difficulty if the decision is complex or involves a number of options. Other patients may be able to make decisions at certain times but not others, because fluctuations in their condition impair their ability to understand, retain or weigh up information, or communicate their wishes.

67. If a patient's capacity is affected in this way, you must...[take] particular care to give the patient the time and support they need to maximise their ability to make decisions for themselves. For example, you will need to think carefully about the extra support needed by patients with dementia or learning disabilities.

68. You must take all reasonable steps to plan for foreseeable changes in a patient's capacity to make decisions. This means that you should:

- discuss treatment options in a place and at a time when the patient is best able to understand and retain the information
- ask the patient if there is anything that would help them remember information, or make it easier to make a decision; such as bringing a relative, partner, friend, carer or advocate to consultations, or having written or audio information about their condition or the proposed investigation or treatment
- speak to those close to the patient and to other healthcare staff about the best ways of communicating with the patient, taking account of confidentiality issues.

69. *If a patient is likely to have difficulty retaining information, you should offer them a written record of your discussions, detailing what decisions were made and why.*

70. *You should record any decisions that are made, wherever possible while the patient has capacity to understand and review them...*

(Consent: patients and doctors making decisions together, paragraphs 66-70)

71. *You must assess a patient's capacity to make a particular decision at the time it needs to be made. You must not assume that because a patient lacks capacity to make a decision on a particular occasion, they lack capacity to make any decisions at all, or will not be able to make similar decisions in the future.*

72. *You must take account of the advice on assessing capacity in the Codes of Practice that accompany the Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000 and other relevant guidance. If your assessment is that the patient's capacity is borderline, you must be able to show that it is more likely than not that they lack capacity.*

73. *If your assessment leaves you in doubt about the patient's capacity to make a decision, you should seek advice from:*

a. nursing staff or others involved in the patient's care, or those close to the patient, who may be aware of the patient's usual ability to make decisions and their particular communication needs

b. colleagues with relevant specialist experience, such as psychiatrists, neurologists, or speech and language therapists.

74. *If you are still unsure about the patient's capacity to make a decision, you must seek legal advice with a view to asking a court to determine capacity.*

(Consent: patients and doctors making decisions together, paragraphs 71-74)

2. James Thompson is a 48 year old man. He has become angry with practice staff in the past and has always had a poor relationship with his main GP, Dr Wood.

James attended the surgery three days ago with a chest infection and was mistakenly given penicillin which he'd had a reaction to in the past. He now has an appointment with Dr Isreb.

James: Thanks for the emergency appointment. I don't know why this thing isn't shifting. I feel just as bad as I did when I last came in and I've got this itchy rash.

Dr Isreb: Well I've checked your records, Mr Thompson, and I'm afraid Dr Wood shouldn't have prescribed you penicillin. Your records show you've had a bad reaction to it in the past...

James: And he just went ahead and prescribed it to me anyway? Why didn't he check my records? That's just incompetence! This place is useless!!!!

What should the doctor do next...? (Circle A, B or C).

A: Tell Mr Thompson that you will launch an investigation and report to him in a few days.

B: Offer to make an appointment for him to see Dr Wood when he returns from leave so he can explain and apologise to James himself?

C: Apologise on Dr Woods' behalf and explain what is likely to happen now in terms of symptoms and the best treatment?

See what the doctor did

Dr Isreb apologises for the mistake and talks James through its likely consequences. Although Dr Isreb is wary of James's aggressive manner (and aware that he may be justified in ending the consultation in accordance with the NHS non-physical assault policy), he can understand why James is angry. He tells him this and hopes that apologising for the mistake will calm James down. He also tells him that the incident will be discussed at the next practice meeting to ensure they learn from it. James leaves calmer but determined to make a complaint about Dr Wood's incompetence so he can be stopped from working 'before he kills someone'.

References

You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you must:

a. Put matters right (if that is possible)

b. Offer an apology

c. Explain fully and promptly what has happened and the likely short-term and long-term effects. (Good Medical Practice paragraph 55)

3. Amanda, a 27 year old woman, has come to see her GP Dr Carter for the results of some tests (for sexual transmitted infections). Amanda's partner, Chris, also has the same GP, although Amanda does not know this. Last week Dr Carter told Chris that he is HIV positive.

Dr Carter: Well, Amanda, the test results all came back negative, so everything's fine there, no concerns.

Amanda: Thank goodness for that! Phew, what a relief! Not that I imagined the results would be any different. But...actually doctor can I tell you something? I'm going to see if I can persuade my partner to start trying for a baby!

Dr Carter: I see...does your partner, Chris, mean to have these tests done as well? Many couples decide to have them done, just to make sure everything's okay, before trying for children.

Amanda: Yes, absolutely. In fact, Chris already had some tests done, as he's been thinking of binning the condoms and me going on the pill. His results came back last week and everything's fine.

What should the doctor do next...? (Circle A, B or C)

A: Tell Amanda that Chris is HIV positive because she has a right to know she is at risk of infection?

B: Call Chris and try to persuade him to tell Amanda the truth about his test results?

C: Do not tell Amanda Chris is HIV positive because it is Chris's confidential medical information and she has no right to know?

See what the doctor did

Dr Carter did not disclose anything to Amanda immediately, but instead called Chris as soon as Amanda left the clinic, and tried to persuade him to tell her himself. He also said that he would consider telling Amanda directly if he chose not to and Amanda remained at risk of infection.

Chris was very angry that Dr Carter was considering breaching his confidentiality. Dr Carter explained that he had a responsibility to tell her he was HIV positive if they were going to have unprotected sex, though he did not disclose what Amanda had told him about wanting to try for a baby.

Although Chris was still reluctant to talk to Amanda, he agreed to come to the surgery the next day to speak to Dr Carter about it in more detail. Dr Carter resolved that, if he could not persuade Chris to tell Amanda - or if he failed to show for the appointment - he would disclose information to Amanda without Chris's consent.

References

You may disclose information to a known sexual contact of a patient with a sexually transmitted serious communicable disease if you have reason to think that they are at risk of infection and that the patient has not informed them and cannot be persuaded to do so. In such circumstances, you should tell the patient before you make the disclosure, if it is practicable and safe to do so. You must be prepared to justify a decision to disclose personal information without consent. (Confidentiality: disclosing information about serious communicable diseases, paragraphs 13-15)

4. Dr Wood has recently returned to work after the death of his wife following a long illness. He has been the subject of a complaint from James Thompson, to whom he mistakenly prescribed penicillin in spite of the fact that his penicillin allergy was on record. Dr Wood has continued to underperform since his return to work. The receptionist comes to see Dr Smith because she's concerned that patients may be at risk.

Receptionist: Honestly Dr Smith, I gave him the patient records for this morning's surgery and he looks awful - I can't imagine he's getting any sleep. And I'm sure I caught a whiff of alcohol too.

Dr Smith: Well he's had a lot to deal with recently. I've suggested he has more time off but he keeps saying that work's the only thing that's keeping him going.

Receptionist: Yes but that's not the issue is it? I mean what happens if he makes another mistake? Or what if he's started drinking again? You know what happened last time...

What should the doctor do next...? (Circle A, B or C)

A: Immediately Report Dr Wood to the GMC?

B: Speak to Dr Wood when surgery is over, and try to persuade him to have more time off?

C: Seek the GMC's advice without giving Dr Wood's name, and speak to your surgery's senior partner and practice manager?

See what the doctor did

Dr Smith decided to call the GMC for confidential advice, and to help him come to a view about the risk to patients. He went in to see Dr Wood immediately after speaking to the GMC, told him he had decided to inform the Primary Care Trust (PCT) and asked him to stop seeing patients immediately. Dr Smith was very supportive and persuaded Dr Wood to go to his GP and to make an appointment with a counsellor.

References

You must support colleagues who have problems with their performance or health. But you must put patient safety first at all times. (Good Medical Practice paragraph 43)

Appendix 4. Attendee participant information sheet

Participant Information Sheet: Evaluation of Welcome to UK Practice

You are invited to take part in a study evaluating the Welcome to UK Practice (WtUKP) workshop. Before you decide whether you would like to participate, here is some information about why the research is being conducted and what will be involved. Please read this and contact the researchers if you would like any further information.

1. What is the purpose of the research study?

The main purpose of this research is to evaluate the content and delivery of WtUKP. We hope this work will inform future events and have a beneficial impact on the working lives of overseas medical graduates working in the NHS.

2. Why have I been chosen?

All attendees of WtUKP are invited to take part in this evaluation.

3. Do I have to take part?

No, participation in this study is entirely voluntary. If you do not wish to be involved you do not need to take part, and if you do decide to take part you may withdraw at any time, without giving a reason.

4. What will happen to me if I take part?

At the beginning and at the end of the WtUKP sessions, you will be asked to complete a questionnaire. Completing this questionnaire should take around 20 minutes. You will be invited to complete a follow-up questionnaire in three months' time. As a thank you, we would like to offer you a £10 gift voucher upon completing the three month follow-up questionnaire.

In addition, you may have chosen to take part in a focus group at the end of the WtUKP event. We will ask you to discuss what you thought about the workshop. This may last up to 90 minutes. As a thank you, you will be offered an additional £10 gift voucher for taking part.

At a later date, you may also be invited to take part in a short telephone interview. If you agree, we will contact you to arrange a suitable time. Further information will be sent to you about the interview process (again, a £10 gift voucher will be offered). With your permission the focus group and interview data will be audio recorded.

5. What will happen to the data that is collected?

All information that you provide will remain anonymous. The data from completed questionnaires will undergo analysis by the researchers. The audio recordings of focus groups and interviews will be transcribed and then analysed by the researchers. No personally identifiable data will be included in the transcripts. We may publish direct quotations, but these would be entirely anonymous.

No identifiable individual data will be reported or shared with the GMC. All data will be stored on a secure database for 5 years.

6. What will happen to the results of the research study?

Findings will be used to help inform future design and delivery of the WtUKP. Findings may also be disseminated through publications and conferences. However, there will be no way to identify individuals who contributed to the research.

7. Will my taking part in this study be kept confidential?

Any information collected from you during the course of the evaluation will be kept confidential. You cannot be identified in any way.

8. Who is organising and funding the research?

The research is funded by the General Medical Council and is being led by Dr Amelia Kehoe. This research project has been reviewed and approved by Newcastle University Ethics Committee.

9. Whom to contact for further information

If you have any further questions about this evaluation, please feel free to contact:

Amelia.Kehoe@newcastle.ac.uk or Jan.Illing@newcastle.ac.uk

Appendix 5. Attendee follow up WtUKP questionnaire

Welcome to UK Practice (WtUKP) evaluation

Please complete this online questionnaire **three months after attending** the WtUKP workshop.

Individual responses will remain wholly **confidential**. All data will be anonymised and no identifiable data will be reported or shared with the GMC.

This questionnaire aims to identify your views three months after you took part in the WtUKP workshop and will help the GMC to identify how best to help doctors from overseas in practice.

This is the third and final questionnaire. So that we can link your questionnaires, please enter the last 4 digits of your GMC Unique ID:

1.

Code: _ _ _ _

(Last 4 digits of your GMC UID)

A. Practice in the UK

How much do you agree with the following statements? (please tick)	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Neither Agree nor Disagree ⁴	Somewhat Agree ⁵	Agree ⁶	Strongly Agree ⁷
2. I <i>am aware</i> I will need to adjust my practice to fit the UK medical system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I <i>am aware</i> of the challenges I may face practising medicine in the UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I <i>understand</i> the role of the GMC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I <i>do not feel able</i> to deal with cultural differences that I may face in practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I <i>do not understand</i> the structure and hierarchy of the NHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I <i>am comfortable</i> working as part of a multidisciplinary team <i>i.e. working in a team with other doctors, nurses, health care assistants etc.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I <i>am comfortable</i> asking others for help if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I <i>understand</i> how to communicate with patients' relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I <i>am not aware</i> of how to challenge poor behaviour of a senior colleague	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I <i>am aware</i> of the need to be open and honest with patients following an error or mistake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I feel the GMC <i>are supportive</i> of doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you <i>aware</i> of GMC guidance for doctors (for example <i>Good Medical Practice, Consent, Confidentiality and other guidance</i>)	Yes ¹ <input type="checkbox"/>		No ² <input type="checkbox"/>				
If NO , go to Q18							
How much do you agree with the following statements? (please tick)	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Neither Agree nor Disagree ⁴	Somewhat Agree ⁵	Agree ⁶	Strongly Agree ⁷
14. When I have a professional dilemma, I <i>will</i> consult GMC guidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I <i>understand</i> how to apply GMC guidance on consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I <i>understand</i> how to apply GMC guidance on confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I <i>understand</i> how to apply GMC guidance on how to raise a patient safety concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Your views on patients

The list below shows 18 statements concerning the patient-doctor relationship within the NHS.
Please indicate to which extent you agree with each of the following statements (please tick).

	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Somewhat Agree ⁴	Agree ⁵	Strongly Agree ⁶
18. The doctor is the one who should decide what is talked about during a consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Although health care is less personal these days, this is a small price to pay for medical advance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. The most important part of the standard medical visit is the physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. It is often best for patients if they do not have a full explanation of their medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Patients should rely on their doctors' knowledge and not try to find out about their conditions on their own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. When doctors ask a lot of questions about a patient's background, they are prying too much into personal matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. If doctors are truly good at diagnosis and treatment, the way they relate to patients is not that important	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Many patients continue asking questions even though they are not learning anything new	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Patients should be treated as if they were partners with the doctor, equal in power and status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Patients generally want reassurance rather than information about their health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. If a doctor's primary skills are being open and warm, the doctor will not have a great deal of success	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. When patients disagree with their doctor, this is a sign that the doctor does not have the patient's respect and trust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. A treatment plan cannot succeed if it is in conflict with a patient's lifestyle or values	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Most patients want to get in and out of the doctor's office as quickly as possible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. The patient must always be aware that the doctor is in charge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. It is not that important to know a patient's culture and background in order to treat the person's illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Humour is a major ingredient in the doctor's treatment of the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. When patients look up medical information on their own, this usually confuses more than it helps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Communication Skills in the UK

Below is a list of tasks that you may face when practising. Please indicate how certain you are that you can successfully perform each of the following tasks (*please circle*).

	1 = Very uncertain			5 = Very certain	
36. Initiate a conversation with a patient regarding his/her worries	1	2	3	4	5
37. Conclude a consultation with a summary of the problem(s) and a treatment plan	1	2	3	4	5
38. Assess symptoms of anxiety and depression	1	2	3	4	5
39. Communicate bad news to a patient	1	2	3	4	5
40. Confront in an appropriate manner a patient who denies his/her illness	1	2	3	4	5
41. Cope with a situation in which a patient or a relative expresses disagreement with you as a doctor	1	2	3	4	5
42. Encourage a patient to describe his/her feelings	1	2	3	4	5
43. Explore intense emotions, such as anger, in a patient	1	2	3	4	5
44. Help a patient cope with an uncertain situation	1	2	3	4	5

D. Applying what you learn from WtUKP into your practice

51. Are you currently in practice in the UK or have you practised in the UK since attending WtUKP? **YES**¹ / **NO**² (*please circle*)

If **YES to Q45**, how long have you been/were you in practice? Years: Months:

If **YES to Q45**, What is/was your job title?

If **NO to Q45**, go to **Q48**

52. Have you changed your practice as a result of anything you learnt during WtUKP? **YES**¹ / **NO**² (*please circle*)

If **YES**, what did you change? If **NO**, why not?

53. Have you been using and applying the guidance and tools that were discussed in WtUKP? **YES**¹ / **NO**² (*please circle*)

54. Did WtUKP help you in any other ways? (please explain)

55. How will you apply what you have learnt from WtUKP in the future? How will this help you to progress in your career?

56. Reflecting back on the last three months, is there anything the GMC could have included in WtUKP that would have been helpful to your practise in the UK?

57. What other support do you think is most needed for doctors transitioning to medical practice in the UK?

58. What have been the most challenging aspects of adjusting to living and working in the UK?

Multiple choice:

Religion in the UK, Culture in the UK, UK law/different legal framework, Finance, Social Aspects, Language, Communication, Accommodation, Relationships with colleagues, Home sickness, NHS structure, Hospital environment, Dealing with different sorts of people, Lack of information provided, relationships with patients OTHER

59. Thinking about your overall transition to the UK, is there anything else that the GMC could have done to support you into UK practice?

60. Following WtUKP, has your perception of the GMC changed? **YES**¹ / **NO**² (please circle)
If **YES**, what role did WtUKP play in this?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

If you have any questions, please contact Amelia Kehoe (amelia.kehoe@newcastle.ac.uk)

Appendix 6. Non-attendee questionnaire

Welcome to UK Practice (WtUKP) evaluation

We want to support all overseas qualified doctors, including those who were unable to attend the WtUKP workshop. We are therefore sending you this questionnaire to help us identify what difficulties you may face in UK practise and how the GMC can best support you. We would be grateful if you could spend 10-15 minutes completing this questionnaire to help us to understand what your needs are.

Individual responses will remain wholly **confidential**. All data will be anonymised and no identifiable data will be reported or shared with the GMC.

A. Practice in the UK

How much do you agree with the following statements? (please tick)	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Neither Agree nor Disagree ⁴	Somewhat Agree ⁵	Agree ⁶	Strongly Agree ⁷	
2. I <i>am aware</i> I will need to adjust my practice to fit the UK medical system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. I <i>am aware</i> of the challenges I may face practising medicine in the UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. I <i>understand</i> the role of the GMC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. I <i>do not feel able</i> to deal with cultural differences that I may face in practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. I <i>do not understand</i> the structure and hierarchy of the NHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. I <i>am comfortable</i> working as part of a multidisciplinary team <i>i.e. working in a team with other doctors, nurses, health care assistants etc.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. I <i>am comfortable</i> asking others for help if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. I <i>understand</i> how to communicate with patients' relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. I <i>am not aware</i> of how to challenge poor behaviour of a senior colleague	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. I <i>am aware</i> of the need to be open and honest with patients following an error or mistake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. I feel the GMC <i>are</i> supportive of doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Are you <i>aware</i> of GMC guidance for doctors (for example <i>Good Medical Practice, Consent, Confidentiality and other guidance</i>)	Yes ¹ <input type="checkbox"/>	No ² <input type="checkbox"/>						
If NO , go to Q18								
How much do you agree with the following statements? (please tick)	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Neither Agree nor Disagree ⁴	Somewhat Agree ⁵	Agree ⁶	Strongly Agree ⁷	
14. When I have a professional dilemma, I <i>will</i> consult GMC guidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. I <i>understand</i> how to apply GMC guidance on consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. I <i>understand</i> how to apply GMC guidance on confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. I <i>understand</i> how to apply GMC guidance on how to raise a patient safety concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

B. Your views on patients

The list below shows 18 statements concerning the patient-doctor relationship within the NHS.
Please indicate to which extent you agree with each of the following statements (please tick).

	Strongly Disagree ¹	Disagree ²	Somewhat Disagree ³	Somewhat Agree ⁴	Agree ⁵	Strongly Agree ⁶
18. The doctor is the one who should decide what is talked about during a consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Although health care is less personal these days, this is a small price to pay for medical advance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. The most important part of the standard medical visit is the physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. It is often best for patients if they do not have a full explanation of their medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Patients should rely on their doctors' knowledge and not try to find out about their conditions on their own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. When doctors ask a lot of questions about a patient's background, they are prying too much into personal matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. If doctors are truly good at diagnosis and treatment, the way they relate to patients is not that important	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Many patients continue asking questions even though they are not learning anything new	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Patients should be treated as if they were partners with the doctor, equal in power and status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Patients generally want reassurance rather than information about their health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. If a doctor's primary skills are being open and warm, the doctor will not have a great deal of success	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. When patients disagree with their doctor, this is a sign that the doctor does not have the patient's respect and trust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. A treatment plan cannot succeed if it is in conflict with a patient's lifestyle or values	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Most patients want to get in and out of the doctor's office as quickly as possible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. The patient must always be aware that the doctor is in charge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. It is not that important to know a patient's culture and background in order to treat the person's illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Humour is a major ingredient in the doctor's treatment of the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. When patients look up medical information on their own, this usually confuses more than it helps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Communication Skills

Below is a list of tasks that you may face when practising. Please indicate how certain you are that you can successfully perform each of the following tasks (*please circle*).

	1 = Very uncertain			5 = Very certain	
36. Initiate a conversation with a patient regarding his/her worries	1	2	3	4	5
37. Conclude a consultation with a summary of the problems and a treatment plan	1	2	3	4	5
38. Assess symptoms of anxiety and depression	1	2	3	4	5
39. Communicate bad news to a patient	1	2	3	4	5
40. Confront in an appropriate manner a patient who denies his/her illness	1	2	3	4	5
41. Cope with a situation in which a patient or a relative expresses disagreement with you as a doctor	1	2	3	4	5
42. Encourage a patient to describe his/her feelings	1	2	3	4	5
43. Explore intense emotions, such as anger, in a patient	1	2	3	4	5
44. Help a patient cope with an uncertain situation	1	2	3	4	5

D. Demographics

50. What nationality are you?

51. What is the country where you obtained your primary medical qualification?
.....

52. How long ago did you obtain your primary medical qualification? **Years**..... **Months**.....

53. How many years of postgraduate medical training have you had, if any? **Years**..... **Months**.....

54. Date of registration with the GMC?

50. Are you currently living in the UK? YES ¹ / NO ² (<i>please circle</i>)	
If YES please answer Q51 to Q54 BELOW and then move to Q56	If NO please answer Q55 BELOW and then move to Q56
51. How long have you been living in the UK? Years Months	55. What country are you currently living in?
52. Where in the UK are you currently living?	
53. What was the last country you were practising in before moving to the UK?	
54. What best describes your last job role before moving to the UK?	

56. Are you currently practising medicine? YES ¹ / NO ² (please circle)	
If YES please answer Q57 to Q59 BELOW and then move to Q61	If NO please answer Q60 BELOW and then move to Q61
57. Where do you currently work?	60. How long has it been since you practised medicine? Years Months
58. What best describes your current job title?	
59. How long have you been in this role? Years Months	

61. Which specialty do you intend to work in?

62. Are you...? <input type="checkbox"/> Male ¹ <input type="checkbox"/> Female ² <input type="checkbox"/> Do not wish to disclose ³	63. What is your age? <input type="checkbox"/> 18-24 ¹ <input type="checkbox"/> 25-34 ² <input type="checkbox"/> 35-44 ³ <input type="checkbox"/> 45-54 ⁴ <input type="checkbox"/> 55 or over ⁵ <input type="checkbox"/> Do not wish to disclose ⁶
64. What is your marital status? <input type="checkbox"/> Single ¹ <input type="checkbox"/> Married ² <input type="checkbox"/> Cohabiting ³ <input type="checkbox"/> Divorced ⁴ <input type="checkbox"/> Widowed ⁵ <input type="checkbox"/> Other ⁶ <input type="checkbox"/> Do not wish to disclose ⁷	
65. Do you have dependents? (e.g. children): <input type="checkbox"/> Yes ¹ <input type="checkbox"/> No ² <input type="checkbox"/> Do not wish to disclose ³	
66. In which ethnic group do you classify yourself?	
<u>White</u> <input type="checkbox"/> British ¹ <input type="checkbox"/> Irish ² <input type="checkbox"/> Any other white background ³	<u>Mixed</u> <input type="checkbox"/> White & Black African ⁴ <input type="checkbox"/> White & Black Caribbean ⁵ <input type="checkbox"/> White & Asian ⁶ <input type="checkbox"/> Any other mixed background ⁷
<u>Asian</u> <input type="checkbox"/> Indian ⁸ <input type="checkbox"/> Pakistani ⁹ <input type="checkbox"/> Bangladeshi ¹⁰ <input type="checkbox"/> Chinese ¹¹ <input type="checkbox"/> Any other Asian background ¹²	<u>Black</u> <input type="checkbox"/> Caribbean ¹³ <input type="checkbox"/> African ¹⁴ <input type="checkbox"/> Any other black background ¹⁵ <input type="checkbox"/> Arab ¹⁶ <input type="checkbox"/> Do not wish to disclose ¹⁷

67. What is your religion?

- | | | |
|---|--|---|
| <input type="checkbox"/> Christian ¹ | <input type="checkbox"/> Sikh ⁵ | <input type="checkbox"/> Do not wish to disclose ⁹ |
| <input type="checkbox"/> Muslim ² | <input type="checkbox"/> Jewish ⁶ | |
| <input type="checkbox"/> Buddhist ³ | <input type="checkbox"/> Other ⁷ (Please state) | |
| <input type="checkbox"/> Hindu ⁴ | <input type="checkbox"/> None ⁸ | |

68. Which WtUKP workshop were you unable to attend? (drop down list online)

31/01/2018	Newcastle, Copthorne Hotel Quayside
15/02/2018 AM	London office
15/02/2018 PM	London office
20/02/2018	Manchester office
22/02/2018	Ysbyty Gwynedd post grad centre, Bangor, Wales
24/02/2018 AM	London office
03/03/2018 PM	London office
08/03/2018	Edinburgh office
10/03/2018	Manchester office
14/03/2018	Manchester office
15/03/2018	Cambridge
20/03/2018 AM	London office
20/03/2018 PM	London office
14/04/2018 PM	London office
18/04/2018 AM	London office
18/04/2018 PM	London office
23/04/2018	Brighton
25/04/2018	Manchester office
27/04/2018	Brighton

69. What was the main reason you were not able to attend the WtUKP workshop? Choose 1 reason:

- Unable to get time off work¹
- Lack of child care²
- Too far to travel³
- Too expensive to travel⁴
- Sickness⁵
- Could not see the benefit of attending⁶
- Already attended a similar event⁷
- Other⁹ (*Please state*)

70. Do you intend to attend a WtUKP in the future? **YES**¹ / **NO**²

If **NO**, why not?

71. Is there anything that would make you more likely to attend a workshop in the future?

72. Are you aware of the WtUKP **self-assessment online tool**? (multiple choice questions specific to doctors from overseas) **YES**¹ / **NO**² (*please circle*)

If **YES**, have you used it? **YES**¹ / **NO**² (*please circle*)

If **YES**, how useful was this online tool? If **NO**, what is the reason for not accessing it?

73. What support do you think is most needed for doctors transitioning to medical practice in the UK?

74. What have been the most challenging aspects of adjusting to living and working in the UK?

Multiple choice:

Religion in the UK, Culture in the UK, UK law/different legal framework, Finance, Social Aspects, Language, Communication, Accommodation, Relationships with colleagues, Home sickness, NHS structure, Hospital environment, Dealing with different sorts of people, Lack of information provided, OTHER

75. Thinking about your overall transition to the UK, is there anything else that the GMC could have done to support you into UK practice?

76. What is your current perception of the role of the GMC? Has this changed at all?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

If you have any questions, please contact Amelia Kehoe (amelia.kehoe@newcastle.ac.uk)

Appendix 7. Non-attendee information sheet

Participant Information Sheet: Welcome to UK Practice Evaluation (non-attendance)

You are invited to take part in a study evaluating the Welcome to UK Practice (WtUKP) workshop. Before you decide whether you would like to participate, here is some information about why the research is being conducted and what will be involved. Please read this and contact the researchers if you would like any further information.

1. What is the purpose of the research study?

The purpose of this research is to enable us to identify how the GMC can best support more doctors to attend WtUKP and what difficulties overseas doctors may face in practice if they are not given sufficient guidance and information beforehand. We hope this work will inform future events and have a beneficial impact on the working lives of overseas medical graduates working in the NHS.

2. Why have I been chosen?

All individuals that signed up for WtUKP, but were **unable** to attend, are also invited to take part in this evaluation.

3. Do I have to take part?

No, participation in this study is entirely voluntary. If you do not wish to be involved you do not need to take part, and if you do decide to take part you may withdraw at any time, without giving a reason.

4. What will happen to me if I take part?

You will be asked to complete a short online questionnaire. As a thank you, we will send you a £10 gift voucher.

You may also be invited to take part in a short telephone interview. If you agree, we will contact you to arrange a suitable time. Further information will be sent to you about the interview process (again, a £10 gift voucher will be offered). With your permission the interview data will be audio recorded.

5. What will happen to the data that is collected?

All information that you provide will remain anonymous. The data from completed questionnaire will undergo analysis by the researchers. The audio recordings of interviews will be transcribed and then analysed by the researchers. No personally identifiable data will be included in the transcripts. We may publish direct quotations, but these would be entirely anonymous.

No identifiable individual data will be reported or shared with the GMC. All data will be stored on a secure database for 5 years.

6. What will happen to the results of the research study?

Findings will be used to help inform future design and delivery of the WtUKP programme. Findings may also be disseminated through publications and conferences. However, there will be no way to identify individuals who contributed to the research.

7. Will my taking part in this study be kept confidential?

Any information collected from you during the course of the evaluation will be kept confidential. You cannot be identified in any way.

8. Who is organising and funding the research?

The research is funded by the General Medical Council and is being led by Dr Amelia Kehoe. This research project has been reviewed and approved by Newcastle University Ethics Committee.

9. Whom to contact for further information

If you have any further questions about this evaluation, please feel free to contact:

Amelia.Kehoe@newcastle.ac.uk or Jan.Illing@newcastle.ac.uk

Appendix 8. Researcher observation form

Researcher name: Facilitator: Expected no of attendees: Actual no of attendees:

Date: Venue: Room layout: No of attendees late (unable to complete Q):

AM/PM:

Content correct? (tick if covered)	Comment on key delivery (please link to relevant section of content)	Comment on key interactions and engagement of attendees (including questions asked)
<p>Welcome and introductions <input type="checkbox"/></p> <p>Introduction to session - aims, learning outcomes, content and methods <input type="checkbox"/></p> <p>GMC role, function and our guidance <input type="checkbox"/></p> <p>Why use the guidance? <input type="checkbox"/></p> <p>Duties of a doctor <input type="checkbox"/></p> <p>Trust in the medical profession <input type="checkbox"/></p>		
<p>Getting to know each other using the GMC guidance: Sometimes, always and never</p> <ul style="list-style-type: none"> • Gifts <input type="checkbox"/> • Prescribing <input type="checkbox"/> • Confidentiality <input type="checkbox"/> 		
<p>Introduce and play 'Things I wish I had known' video <input type="checkbox"/></p> <p>Discussion of video <input type="checkbox"/></p>		

<p>Feedback top tip from each group & list on flip chart (if time) <input type="checkbox"/></p> <p>Learning log <input type="checkbox"/></p>		
<p>Exploring Good Medical Practice <input type="checkbox"/></p> <p>Scenarios to highlight professional and ethical issues</p> <ul style="list-style-type: none"> • Mr James <input type="checkbox"/> • Mr Hughes <input type="checkbox"/> • Andrew <input type="checkbox"/> • Mr Jones (if time?) <input type="checkbox"/> <p>Confidentiality in a communicable diseases context <input type="checkbox"/></p> <p>Confidentiality when dealing with children and young people <input type="checkbox"/></p> <p>Learning log <input type="checkbox"/></p>		
<p>Summarise session <input type="checkbox"/></p> <p>Take away messages <input type="checkbox"/></p>		
<p>Other researcher comments and general impressions (atmosphere):</p>		

Appendix 9. Focus group topic guide

Welcome to UK Practice (WtUKP)

Topic guide – focus group

Preamble: Thank you very much for agreeing to take part in this focus group. As you know, the purpose of this session is to gain your feedback on how useful you found the WtUKP workshop you just attended. We plan to discuss what you have learnt and how this will help you to practise as a doctor in the UK. We would also like to understand how the WtUKP workshop could be improved in the future. Gathering your opinions will help us to make recommendations about how to do that. We are going to guide you in a discussion and will be repeating these sessions with a number of other groups and summarising people's views.

If you are happy, we will tape record this session to help us analyse the themes from our discussion today. This discussion will remain wholly confidential and no identifiable data will be shared with the GMC. On the table in front of you is a consent form. If you are happy to take part, please can you sign this. We have up to an hour and a half, aiming to finish at (time).

1. What were the most useful parts of the workshop?
 - *Ensure the 'things I'd wish I'd know' video is discussed*
 - *'Must' and 'should' questions surprising? E.g. that you 'must' have insurance.*
2. Were there any areas that you did not find useful?
(Not clear, or needed more depth? Not relevant?)
3. What have you learnt about raising a **patient safety concern**?
(This includes dealing with your own errors, witnessing those of others or other patient safety concerns)
 - *Can you give examples from the workshop? Was anything a surprise?*
 - *How different is this from your previous training? (Can you give an example?)*
4. What have you learnt about taking **patient consent** in the UK?
 - *Can you give examples from the workshop? Was anything a surprise?*
 - *How different is this from your previous training? (Can you give an example?)*
5. What have you learnt about **patient confidentiality** in the UK?
 - *Can you give examples from the workshop? (about breaching patient confidentiality) Was anything a surprise?*
 - *How different is this from your previous training? (Can you give an example?)*
6. What have you learnt about the **role of the GMC**?
 - *Has your perception about the GMC changed?*
 - *Were you aware of the available resources and guidance?*
 - *Would you engage more with the GMC now if you face an ethical dilemma?*
7. Was anything not covered in the workshop that you felt should have been? Any improvements you think should be made?
8. Thinking about what you have learnt today - how do you plan to apply this into your practice?
 - *Will you do anything differently as a result of this training? (Are there any barriers to doing this?)*
9. Has the workshop provided you with any peer-support/opportunity to meet doctors in a similar situation?
10. Have any of you looked at the WtUKP self-assessment online tool?
(All participants would have been sent a link via an email. Tool includes variety of multiple choice online scenarios to work through - about laws, policy, patient safety, confidentiality etc...)

If **YES**, was it useful? *(Discuss some scenarios)*

If **NO**, Why? *(Discuss ease of access/time etc.)*

- *Do you think other elements of WtUKP/support could be effectively delivered digitally?*

11. Did you have any issues attending the workshop today?

(Any problems booking on to the workshop? Time and location? Did you receive any support in attending? Were you given enough time to arrange taking time off from work/cost/travel/ childcare etc?)

12. What do you think would incentivise more doctors to attend WtUKP?

(e.g. CPD points)

Thank you very much for your participation. We have some vouchers for you (give out).

Appendix 10. Attendee interview topic guide

Welcome to UK Practice (WtUKP)

Interview schedule (3 months post workshop) – interview targeted at attendees who are in practice

Preamble: Thank you very much for agreeing to be interviewed. Can I remind you that the purpose of this interview is to evaluate WtUKP, and if possible make recommendations about how to improve it. This interview is to find out how you have been getting on in practise since you attended the WtUKP workshop (3 months ago).

The questions will focus on how attending the WtUKP helped your practise, and if not, try and identify why or what additional support you needed.

With your permission, I would like to tape record this interview, this will help us to analyse all the interview data and be sure our analysis is accurate, rather than try and make notes at the same time as interviewing. This interview will remain wholly confidential to the research team and no identifiable data will be shared with anybody. The interview should take about 20 minutes. Are you still happy to take part?

START RECORDER FROM THIS POINT

1. Thinking about what you learnt during WtUKP, can you tell me generally, did it help your practice, and if so how?
(focusing on the last three months)
2. What challenges have you faced during your transition to practise in the UK? Have you received any support with this, from where? What additional support could have helped?
(Think about how the GMC workshop could have helped with this, or it may be that the issue is outside of WtUKP content)

Now I am going to ask you more specifically about some of the issues covered in WtUKP

3. Thinking more specifically about what you learnt about patient confidentiality, how has this impacted on your practice, if at all?
(Probe for more detail and get example of how WtUKP helped)
4. Thinking specifically about what you learnt about patient consent, how has this impacted on your practice, if at all?
(Probe for more detail and get example of how WtUKP helped)
5. Have you had to deal with any issues regarding mental capacity? If so, did WtUKP help you manage this, or not?
(Probe for more detail and get example of how WtUKP helped)
6. Thinking specifically about what you learnt about duty of candour and raising concerns about colleagues or practice, how has this impacted on your practise, if at all?
(Probe for more detail and get example of how WtUKP helped)
7. Since attending WtUKP, has your perception of the GMC's role changed?
(If yes, in what way did WtUKP influence this? Is there any more information that you would have liked to have been given about the role of the GMC?)
8. Have you had to contact the GMC about anything since the WtUKP event or asked for any support from them?
*(Probe for details about this
And if not why not)*

9. Since attending the WtUKP event, did you read any of the GMC guidance documents you were given?
*(Probe for details about which ones, how useful are they, how have you applied them into your practise?
And if not why not)*
10. Similarly, did you access any of the GMC online tools or Apps referred to during WtUKP?
*(Probe for details about which ones, how useful, how have you applied them?
And if not, why not)*
11. Looking back, were there any other areas that you wish had been covered in the WtUKP that you think would have helped your practise?
12. When do you think attending WtUKP would be most helpful for overseas doctors?
*(e.g. before reg, at the time of reg, 1st month of practice, 2-3 months etc...
Reflect on their own experience. Why?)*
13. What do you think the most effective way of advertising WtUKP is?
14. *So if you were to recommend WtUKP to a friend, what would you say was the most important part of the day? Why was this so memorable for you?*
15. Thinking about the social side of WtUKP, were you able to make any contacts with the other overseas doctors?
(If so, have you stayed in touch since? If you haven't would you have liked to and do you think the GMC could do more to help you stay in touch?)
16. Lastly, is there anything else you would like to say about the WtUKP event that I have not asked you about?

You may be aware - we are also trying to recruit clinical and/or educational supervisors to take part in this research. The reason for this is to explore supervisor perspectives on Welcome to UK Practice. Please be assured that all information provided by both you and your supervisor will remain confidential and anonymous. Would you be happy to provide contact details of your supervisor if possible?

We could also send you an email to forward on to your supervisor, if you do not feel comfortable disclosing their email address?

Thank you very much for agreeing to talk to me. We will send a voucher to you as soon as possible.

Appendix 11. Supervisor information sheet

Participant Information Sheet: Evaluation of Welcome to UK Practice

You are invited to take part in a study evaluating the GMC's Welcome to UK Practice (WtUKP). Before you decide whether you would like to participate, here is some information about why the research is being conducted and what will be involved. Please read this and contact the researchers if you would like any further information.

10. What is the purpose of the research study?

The main purpose of this research is to evaluate the content and delivery of WtUKP. We hope this work will inform future events and have a beneficial impact on the working lives of overseas medical graduates working in the NHS.

11. Why have I been chosen?

You have been invited to take part in this evaluation because you are a supervisor of a trainee who has attended the GMC WtUKP event. Your trainee has given us permission to contact you and provided your contact information.

12. Do I have to take part?

No, participation in this study is entirely voluntary. If you do not wish to be involved you do not need to take part, and if you do decide to take part you may withdraw at any time, without giving a reason.

13. What will happen to me if I take part?

You will complete a short telephone interview (20-30 minutes). You will be contacted to arrange a suitable time. Further information will be sent to you about the interview process. With your permission, the interview data will be audio recorded.

14. What will happen to the data that is collected?

All information that you provide will remain anonymous. The audio recordings of interviews will be transcribed and then analysed by the researchers. No personally identifiable data will be included in the transcripts. We may publish direct quotations, but these would be entirely anonymous.

No identifiable individual data will be reported or shared with the GMC. All data will be stored on a secure database for 5 years.

15. What will happen to the results of the research study?

Findings will be used to help inform future design and delivery of the WtUKP. Findings may also be disseminated through publications and conferences. However, there will be no way to identify individuals who contributed to the research.

16. Will my taking part in this study be kept confidential?

Any information collected from you during the course of the evaluation will be kept confidential. You cannot be identified in any way.

17. Who is organising and funding the research?

The research is funded by the General Medical Council and is being led by Dr Amelia Kehoe. This research project has been reviewed and approved by Newcastle University Ethics Committee.

18. Whom to contact for further information

If you have any further questions about this evaluation, please feel free to contact:

Amelia.Kehoe@newcastle.ac.uk or charlotte.rothwell@newcastle.ac.uk

Appendix 12. Supervisor interview topic guide

Welcome to UK Practice (WtUKP)

Interview schedule (3 months post workshop) – interview targeted at supervisors of those who attended WtUKP

Preamble: Thank you very much for agreeing to be interviewed. The purpose of this interview is to evaluate the GMCs WtUKP workshop that was attended by one of your supervisees, and if possible make recommendations about how to improve it. This interview is to find out how your supervisee has been getting on in practice since they attended the workshop (3 months ago). This interview is to understand whether WtUKP had been useful and had a positive impact on your supervisee; not to try and monitor /assess their performance.

We would also like to identify what additional support they may have needed during this time.

WtUKP covered areas of GMC guidance that your supervisee should be applying to their practice, such as obtaining consent, maintaining confidentiality, and raising concerns about colleagues or practice and additionally. Asking for help was also emphasised.

With your permission, I would like to tape record this interview, this will help us to analyse all the interview data and be sure our analysis is accurate, rather than try and make notes at the same time as interviewing.

This interview will remain wholly confidential to the research team and no identifiable data will be shared with anybody. The interview should between 10 and 20 minutes. Are you still happy to take part?

1. Firstly, can I ask were you aware that *any of your supervisees from overseas* has attended WtUKP?
Were you aware this workshop existed or what it involved? *(Add some more detail briefly if they were not)*
2. Has there been a chance for *your supervisee* to reflect on what they learnt during WtUKP?
3. What do you think in general are the most challenging areas for non-UK graduates transitioning to UK practice?
Do you think that attending WtUKP has helped your supervisee in these areas?
4. Have you seen a difference in their practice, attitude or confidence at all, particularly in the last 3 months?
5. Thinking specifically about patient confidentiality, do you think that attending WtUKP has had an impact on how they manage this in their practise?
*(If yes, probe for more detail and get example
If not, why)*
6. Thinking specifically about patient consent, do you think that attending WtUKP has had an impact on how they manage this in their practise?
*(Probe for more detail and get example
If not, why)*
7. Have they had to deal with any issues regarding mental capacity?
If so, do you think that attending WtUKP has had an impact on how they managed this?
*(Probe for more detail and get example
If not, why)*
8. Thinking specifically about duty of candour and raising concerns about colleagues or practise, do you think that attending WtUKP has had an impact on how they manage this in their practise?
*(Probe for more detail and get example
If not, why)*

9. Has there been any other issues raised about your supervisee in the last three months?

Have there been any issues to do with any of the following:

Understanding the structure of the NHS

Language or communication

Team working

Asking for help

Workplace based assessments

Revalidation

Appraisal

Career progression

Relationships with colleagues

Relationships with patients

Social or financial aspects

Any other issues such as dealing with bullying

(Probe for details)

10. Reflecting on how your supervisee has transitioned into the workplace, are there any other areas that you think WtUKP should cover?

11. When do you think attending WtUKP would be most helpful for overseas doctors?

(e.g. before reg, at the time of reg, 1st month of practice, 2-3 months etc...

Why?)

12. Do you feel employers are supportive of doctors attending WtUKP?

(Probe for challenges in attending)

13. Is there anything else that the organisation, which you work for, or the GMC could do to support overseas doctors?

14. Lastly, is there anything else you would like to say that we have not covered?

Thank you very much for agreeing to talk to me.

Appendix 13. Non-attendee interview topic guide

Welcome to UK Practice (WtUKP)

Interview schedule – interview targeted at attendees who are in practice and unable to attend WtUKP

Preamble: Thank you very much for agreeing to be interviewed. The purpose of this interview is to find out how you have been getting on in practice as an overseas qualified doctor.

We have interviewed those that attended the GMCs WtUKP workshop, but also individuals like yourself who did not attend, as we are interested in finding out whether all overseas doctors need this type of support or not.

With your permission, I would like to tape record this interview, this will help us to analyse all the interview data and be sure our analysis is accurate, rather than try and make notes at the same time as interviewing. This interview will remain wholly confidential to the research team and no identifiable data will be shared with anybody. The interview should take about 20 minutes. Are you still happy to take part?

START RECORDER FROM THIS POINT

1. Can I clarify, you signed up to attend WtUKP over the last few months, but were unable to attend or decided not to?
2. Is it ok to ask you, why were you unable to attend or decided not to?
(Probe to explore reason)
3. Can I ask why you signed up in the first place? What were your expectations of the day?
Do you still intend to attend WtUKP in the future?
4. Was there anything that the GMC could have done to make it easier for you to attend or that would make you more likely to attend in the future?
5. We would like to ask a few questions about how you are getting on in practise. Can you just give an overview about how your transition into working in the UK has gone?

We are aware that areas of UK practise are likely to be different from where you trained, such as maintaining patient confidentiality, obtaining patient consent and raising concerns. We are interested to know if this has caused you any issues.

6. Thinking specifically about maintaining patient confidentiality, how have you managed this? Have you faced any issues?
*(Probe for more detail and get example
Would support from GMC help? Training?)*
7. How about obtaining patient consent?
*(Probe for more detail and get example
Would support from GMC help? Training?)*
8. Have you had to deal with any issues around mental capacity?
*(Probe for more detail and get example
Would support from GMC help? Training?)*
9. How about raising concerns about colleagues or practise? (this includes duty of candour – being open and honest when things go wrong and saying sorry)
*(Probe for more detail
Would support from GMC help? Training?)*

10. What was your perception of the GMC when you first arrived in the UK?
Following getting your registration with the GMC has your perception changed?
11. Have you had to contact the GMC about anything or asked for any support from them?
*(Probe for details about this
And if not why not)*
12. Have you read any of the GMC guidance documents?
*(Probe for details about which ones, how useful, how have they applied them?
And if not why not)*
13. Have you accessed any of the GMC online tools or apps?
*(Probe for details about which ones, how useful?
And if not, why not, were there any difficulties?)*
14. What challenges have you faced during your transition to practise in the UK?
15. What level of support have you received in these areas and from where?
What additional support would have been helpful?
16. Lastly, is there anything else you would like to say that I have not asked you about?

Thank you very much for agreeing to talk to me. We will send a voucher to you as soon as possible.

Appendix 14. RLA information sheet

Participant Information Sheet: Evaluation of Welcome to UK Practice

You are invited to take part in a study evaluating the GMC's Welcome to UK Practice (WtUKP). Before you decide whether you would like to participate, here is some information about why the research is being conducted and what will be involved. Please read this and contact the researchers if you would like any further information.

What is the purpose of the research study?

The main purpose of this research is to evaluate the content and delivery of WtUKP. We hope this work will inform future events and have a beneficial impact on the working lives of overseas medical graduates working in the NHS.

Why have I been chosen?

All Regional Liaison Advisors who deliver WtUKP have been invited to take part in this evaluation.

Do I have to take part?

No, participation in this study is entirely voluntary. If you do not wish to be involved you do not need to take part, and if you do decide to take part you may withdraw at any time, without giving a reason.

What will happen to me if I take part?

You will complete a short telephone interview (20-30 minutes). You will be will contacted to arrange a suitable time. Further information will be sent to you about the interview process. With your permission, the interview data will be audio recorded.

What will happen to the data that is collected?

All information that you provide will remain anonymous. The audio recordings of interviews will be transcribed and then analysed by the researchers. No personally identifiable data will be included in the transcripts. We may publish direct quotations, but these would be entirely anonymous.

No identifiable individual data will be reported or shared with the GMC. All data will be stored on a secure database for 5 years.

What will happen to the results of the research study?

Findings will be used to help inform future design and delivery of the WtUKP. Findings may also be disseminated through publications and conferences. However, there will be no way to identify individuals who contributed to the research.

Will my taking part in this study be kept confidential?

Any information collected from you during the course of the evaluation will be kept confidential. You cannot be identified in any way.

Who is organising and funding the research?

The research is funded by the General Medical Council and is being led by Dr Amelia Kehoe. This research project has been reviewed and approved by Newcastle University Ethics Committee.

Whom to contact for further information

If you have any further questions about this evaluation, please feel free to contact:
Amelia.Kehoe@newcastle.ac.uk or Jan.Illing@newcastle.ac.uk

Appendix 15. RLA interview topic guide

Interview schedule for RLAs

Preamble: Thank you very much for agreeing to be interviewed. Can I remind you that the purpose of this interview is to evaluate WtUKP, and if possible make recommendations about how to improve it.

With your permission, I would like to tape record this interview, this will help us to analyse all the interview data and be sure our analysis is accurate. This interview will remain wholly confidential to the research team. The interview should take about 20-30 minutes. Are you still happy to take part?

START RECORDER FROM THIS POINT

General

1. Thinking back over the period you have worked as an RLA, what are your thoughts about the current WtUKP workshop?

Local or National (GMC offices) WtUKP

2. Do you deliver local and national workshops? Where do you deliver them?
(by national we mean hosted by the GMC in GMC offices)

Explore the recruitment process -GMC verses Trusts and any differences in doctors attending and any issues with attendance (motivation vs engagement)

3. Do you have any thoughts on whether these events would be best delivered locally or nationally or even regionally?

Please explain why you think this?

4. Do you think WtUKP should be part of local Trust inductions?

If yes, can you think of any challenges to this?

5. What about the introduction of weekend workshops – what are your thoughts on these?

Numbers

6. Do you have any thoughts about the ideal number of delegates?

What would be ideal?

Too large?

And too small?

Does the venue and time effect this?

Timing of workshop

7. Thinking about the time available for the WtUKP workshop - do you think the length of time is right or should it be shorter/longer?

If longer, how much longer –more days?

What would you add in this time?

8. Some people have suggested having a workshop before starting work and another about three months after starting work –what do you think of this suggestion?

Doctors on work or not?

9. Have you noticed any difference between those doctors in practice and those that are not?

Mix of both types?

Important aspects of WtUKP

10. Thinking about the actual WtUKP workshop, what would you identify as the most important part of the day?
11. Is there anything you would identify as being particularly useful in practice?
Which part of WtUKP do you feel has the greatest impact with the doctors?
12. Would you change anything about the order of events on the day?
13. Thinking about the workshops, Is there anything you would specifically remove or add?

Clinical

14. Are you a clinician or not?

If not – do you have other areas of experience or expertise gained prior to becoming an RLA that you are able to draw upon the day? (e.g. law?)
15. Are there any challenges for you individually in delivering WtUKP?
16. What are your thoughts on having a clinician present on the day to pick up specific questions about practice?

GMC challenges

17. Do you think there are challenges for the GMC in delivering WtUKP?

Own Feedback?

18. You collect formal feedback on your evaluation form at the end of the session, what other feedback do you receive from the doctors?
What sort of feedback are you getting from attendees (positive/negative)?

Check recommendations

19. Did you see our interim report that we submitted at the end of April? This highlighted some initial findings from the focus groups. I will run through a couple of the key points:
 - *The elements most positively received were where UK practice was brought to life with scenarios and videos.*
 - *We suggested considering ways to incentivise attendance e.g. through CPD points.*
 - *We suggested extending the workshop to provide more time for discussion of scenarios (e.g. children and young people, the use of chaperones, and communicable diseases), more time for introductions and networking,*
 - *and more time for further relevant input (e.g. revalidation, NHS structure, dealing with negative experiences, and career advice).*

- *Finally we suggested re-emphasising the role of the GMC e.g. “working with doctors, working for patients”(2014), highlighting a positive message about the role of the GMC for doctors, as some IMGs felt the GMC did not promote this well.*

What are your thoughts on the findings?

Are there any other areas you would like to discuss?

20. Lastly, do you have any other ideas about the future of WtUKP?

Thank you very much for agreeing to talk to me.