



PROMOTING EFFECTIVE HEALTH
PARTNERSHIPS WORLDWIDE

GP Trainee Time Out of Programme (OOP): Exploration of Impact on Skills

The International Health Links Centre (IHLC)
& The London Deanery

March 2011

Abbreviations

| | |
|-------|--|
| A & E | Accident and Emergency |
| AHP | African Health Placements (AHP). |
| DH | Department of Health |
| DFID | Department for International Development |
| GP | General Practitioner |
| IHLC | International Health Links Centre |
| LSTM | Liverpool School of Tropical Medicine |
| LSTMH | London School of Hygiene and Tropical medicine |
| OOP | Time Out of Programme Scheme |
| RCGP | Royal College of General Practitioners |
| TB | Tuberculosis |
| THET | Tropical Health and Education Trust |
| TOR | Terms of Reference |
| VSO | Voluntary Services Overseas |



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EXECUTIVE SUMMARY

The aim of this project was to assess the impact of a Time Out of Programme (OOP) scheme designed by the London Deanery and offered to General Practitioner (GP) trainees within the Deanery.

The OOP is used to provide GP trainees with an opportunity to enhance clinical experience and develop a range of skills and competencies which will be relevant and transferable to their practice as a GP in the UK. The programme offers health care posts in the developing world and is made available to trainees between years two and three (ST2 and ST3) or years three and four (ST3 and ST4) of their GP training.

According to the Terms of Reference¹ (TOR) the objective of the project was to evaluate the OOP scheme in terms of the impact of the OOP on:

- GP trainees' clinical skills
- GP trainees' decision making, management and leadership skills
- any other competencies (personal or professional)

and finally to evaluate:

- the limitations of the OOP scheme

The London Deanery has developed a structured OOP programme with in-built quality controls and processes and mechanisms for recruitment, briefing, de-briefing and tracking learning of trainees throughout their OOP placement.

Our findings show that there is an increase in skill levels reported by both trainees and trainers, in the more generic competencies of the Royal College of General Practitioners (RCGP) Competency Framework and Darzi model² and that although there are clinical skill improvements these skills are not always directly transferable to clinical practice work undertaken on return to the UK. At the same time exposure to hands-on clinical practice did seem to provide trainees with greater confidence more generally in their UK practice.

There is little doubt that the skills gained overall are beneficial and transferable to the NHS, and would provide evidence to support that providing GP trainees with an opportunity to work in complicated, poorly resourced and challenging environments has the potential to: enhance skills and competencies difficult to achieve within a three year training programme, strengthen the generalist/specialist interface and equip GP trainees to become future leaders within their profession.

There may be ways in which the OOP can be further enhanced to improve transferability of skills including asking trainees to actively consider this during their OOP placement and plan for how they will fully utilise the skills developed on return to UK.

¹ Annex 1

² Both the RCGP Competency Framework (Annex 7) and Darzi model (Annex 8) were used to rate skills developed by trainees. The Darzi model is a framework which was developed to assess NHS health professionals skills in International Development we have called this the Darzi model throughout the report for ease of reference. The full title given to the model is Tribal Newchurch adaptation of Lord Darzi's Next stage review (2009)



There have been calls to extend training for GPs from a three to a four or five year programme. The fact that the OOP is a well designed and structured programme which follows the Gold Guide *Reference for Postgraduate Specialty Training in the UK*³ means that it is already a good model which could potentially be used as a natural extension to GP training in the future.

³ Gold Guide *Reference Guide for Postgraduate Specialty Training in the UK*.³ Section 6.65 to 6.91 Modernising Medical Careers website www.mmc.nhs.uk. Accessed February 2011



CONTEXT

Context of International Health Links Centre

The goal of the **International Health Links Centre (IHLC)** is to enhance access to health care in the developing world by promoting international partnerships that will increase the number and skills of the health workforce.

The primary role of the Centre is to act as a resource centre for members and potential members providing advice on technical and administrative aspects of establishing and maintaining links.

An additional function of the IHLC is to carry out evaluations of existing links, both within the Department for International Development (DFID) and the Department of Health (DH) funded programme and beyond and conduct comparative analyses of UK links with international practice. The data generated informs practice, policy, implementation and administration of links and provides stakeholders with evidence to shape future development of the IHLC.

The exploration of the impact of the General Practitioner Time Out of Program (OOP) scheme falls within the IHLC evaluation remit.

Context of the Time Out of Programme Scheme at the London Deanery

The General Practitioner **Time Out of Program (OOP) scheme** has been developed by the London Deanery for GP trainees. The OOP is used to provide an opportunity for GP trainees to enhance clinical experience and to provide experience of different working practices in a developing country setting. It aims to provide GPs with an opportunity to enhance a number of competencies, such as building confidence and consolidating and developing clinical, managerial, leadership, cultural and educational skills.

These skills are beneficial and transferable to the NHS. Indeed providing GP trainees with an opportunity to work in complicated, poorly resourced and challenging environments has the potential to strengthen the generalist/ specialist interface and equip GP trainees to become future leaders within their profession.

The London Deanery has developed a menu of overseas OOP posts in developing countries with in-country partner agencies in South Africa and Zambia and Rajasthan. **Excellence and quality control** are key to every aspect of the design of the London Deanery OOP model. The OOP follows the Gold Guide *Reference Guide for Postgraduate Specialty Training in the UK*⁴ and each post is inspected, quality assured and facilitated by the Deanery.

Sustainability is also key to the London Deanery model. The OOP posts offered meet an expressed need of government in the partner country. According to the OOP Programme Director at the London Deanery the programme is 'part of integral care not charitable giving'. In South Africa for example, the South African government tries to fill each clinical post with local Doctors. Only when the post has not been filled by a local doctor does the government seek external applications for

⁴ Gold Guide *Reference Guide for Postgraduate Specialty Training in the UK*.⁴ Section 6.65 to 6.91 Modernising Medical Careers website www.mmc.nhs.uk. Accessed February 2011



which UK GP trainees can apply. The hospital in the host country is responsible for paying the salary of the GP trainee whilst in country. This applies also to posts in Zambia and Rajasthan.

There is a bursary to help trainees cover the costs of flights and GP registration overseas. This bursary is available from the RCGP however, the funding is declining.

GP trainees are provided with a clear job description detailing what is expected of them over the one year OOP period. This is provided by the hospital in the host country. There are built-in terms and conditions to each placement and these are agreed with trainees in advance.

Evidence of learning during the one year placement is formally recorded through an e -portfolio. The e-portfolios are checked each month by the educational supervisor in London. They are also reviewed by the educational supervisor and the trainee at six monthly intervals. Over the period of the OOP there are two of these sessions which last approximately two hours. In addition each placement includes a named national clinical supervisor in the host country who provides on-site supervision for each trainee. The e-portfolios provide formal evidence of what the trainee is doing in the field and require sign-off from the clinical trainer in-country.

The London Deanery works through a partner agency in South Africa, the African Health Placements (AHP). In Zambia and Rajasthan the Deanery works through the hospital which is known to the Deanery. Working through a partner agency has helped with organisational issues including arranging placements and assisting trainees with practical issues before leaving the UK e.g. helping with visas and medical registration and assisting with practical information once in-country.

There are key stages in the process of the OOP. These include:

Recruitment – marketing of the OOP, review of applications, interviews and selection

Orientation – three pre induction meetings in the UK as well as :

- Promotion of UK modules of training e.g. HIV/ TB at LSTM and clinical attachments e.g. Paediatric A+E

Induction

- In Country Induction which is provided by the partner agency, AHP
- In Hospital induction and orientation

Supervision

- Ongoing supervision and professional development are provided through hospital and partner agency
- Educational supervision via the RCGP e portfolio

De-briefing - which takes place approximately one month after trainees return.

Recruitment

In year one of the GP training the trainees are told about the OOP scheme. Trainees can apply at the start of year two and go on placement at end of year two at the earliest. Once trainees apply there is a review and filtering of applications linking job descriptions and terms and conditions to those



applying. Trainees applying undertake an interview to assess suitability. For placements to South Africa, AHP attend the trainee interviews in London. After the interview if trainees are offered a place on the OOP scheme they have two weeks to decide if they are accepting the post which has been offered. At this stage a total of 90% of trainees accept the placement offered. Some GP trainees may have organised their own overseas placement through organisations such as Voluntary Services Overseas (VSO), or similar organisation. The London Deanery supports trainees taking up these types of posts which offer twelve months of overseas medical experience.

Induction

GP trainees meet as a group three times with the Programme Director and a representative from the partner agency before going to the partner country. These meetings provide an opportunity to explore practical operational issues e.g. visas, pensions. They are also used to allow trainees to meet with trainees who have completed the OOP scheme and to learn first hand from their experience. The meetings are also designed to encourage trainees to establish a peer support network before they leave for their placement. They are encouraged to share contact details and to stay in touch via email. In previous years there has been a good support network between GP trainees.

From August 2010 all trainees going to South Africa receive a three day induction in Durban. This was designed to provide trainees with information on local clinical issues such as: the role and importance of traditional healers; clinical practice in rural communities and a township clinic tour. These sessions also covered practical assistance with personal administrative tasks such as opening bank accounts and setting up mobile phones.

Trainees have a break of two weeks before their placements and two weeks before they restart their UK GP training in the UK. This is designed to provide an adjustment period for trainees.

Since 2009 ten GP trainees have completed the OOP in a developing country. Of these, three trainees took part in a pilot scheme where six months of their twelve months practice overseas was accredited as part of their GP training. There are also currently seven trainees who are six months into their OOP and a further eight trainees who have been selected to begin their placements in August 2011. Because of organisational constraints of UK GP training no other GP trainees taking part in the scheme to date have had their experience requested to be accredited.



ASSIGNMENT OVERVIEW SCHEDULE AND ACTIVITIES

SCOPE AND PURPOSE OF ASSIGNMENT

Consultants

The assignment was undertaken by two independent health and development consultants working with the IHLC and the London Deanery.

Specific Objectives of the Assignment

According to the TOR the objective was to evaluate the OOP scheme in terms of the impact of the OOP on:

- GP trainees' clinical skills
- GP trainees' decision making, management and leadership skills
- any other competencies (personal or professional)

and finally to evaluate:

- the limitations of OOP scheme

Approach for the Assignment

The key aim was to have a participatory approach from the outset to ensure the final report matched the information requirements and expectations of the IHLC and the London Deanery.

Briefing sessions were held with the IHLC and the London Deanery at the start of the assignment. Both organisations were fully engaged in the assignment, participating in the development of interview schedules, agreeing the approach for collecting data and assisting with developing the list of interviewees.

The evaluation tools were designed to be simple to administer to ensure the fullest participation of respondents. For example, the structured interview schedule was comprehensive while not being too time intensive to administer, to encourage interviewees to take part.

It was agreed that information be collected through individual and group interviews with GP trainees, GP trainers and key stakeholders who would provide information at a more strategic level on the programme.

Key Activities and Deliverables

The assignment took place between January and March 2011. Interviews were conducted between the 18th February and the 10th March 2011.



Interview schedules were designed and developed by the consultants and reviewed jointly with key stakeholders from the London deanery and the IHLC. A total of three interview schedules were designed and developed for: GP trainees, GP Trainers and Strategic Level Interviewees⁵

A list of key interview contacts was provided by the London Deanery at the start of the assignment. This list was expanded by the consultants and the London Deanery as the assignment progressed. Permission was sought from the GP trainees to interview their GP trainer. Trainees were encouraged to speak to their trainers and once the trainer had agreed to an interview, trainees introduced the trainer to the consultants by email and a suitable time for a short telephone interview was arranged.

The London Deanery suggested four additional interviews with senior RCGP, Deanery and ex-Deanery staff to gain a more strategic view of the OOP and the way forward for the programme. These interviews were conducted in person or by telephone.

All key informant interviews (KII) were arranged by email and telephone. Interviews were conducted in a face-to-face session where possible or by telephone.

GP Trainee Interviews

The majority of interviews with GP trainees were conducted face-to-face (5). Where this was not possible to arrange the interview was conducted by telephone (3). Interviews ranged between 45 minutes to 1.5 hours. We were unable to contact two of the GP trainees who did not respond to email requests for an interview.

GP Trainers

Interviews with GP trainers were all conducted in individual telephone interviews (6 interviews) except with the educational supervisor who had supervised trainees whilst they had been on their placements, this interview was conducted in an face-to-face interview (1 interview). The face-to-face interview took approx 1.5 hours and telephone interviews varied in length from 20-50 minutes.

Strategic Level Interviews

Interviews with strategic level interviewees took place face-to-face or in an individual telephone interview. Two strategic level interviews were conducted by telephone and one face-to-face group session was held with two strategic level interviewees. These interviews ranged in length from 30minutes - 1.5 hours.

Interviews with those overseeing/ planning the assignment from the IHLC and the London Deanery were conducted by telephone. A total of 21 individuals were interviewed (See Table 1).

⁵ Annex 4: Interview Schedules



TABLE 1: Numbers of Trainees, Trainers and Strategic Level Interviewees Contacted and Who Took Part in Interview

| GP Trainees contacted | GP Trainees who completed interview | *GP Trainers contacted | **Trainers Interviewed | Strategic Level Interviewees Contacted and interviewed | Study planners contacted and interviewed |
|-----------------------|-------------------------------------|------------------------|------------------------|--|--|
| 10 | 8 | 8 | 7 | 4 | 2 |

***GP Trainer Contacted**

- *Two of the GP trainees did not respond and subsequently there were no trainers for these GP trainees
- One trainee interviewed is now a qualified GP, and therefore does not have a current trainer
- Another GP trainer was emailed but didn't respond to the request for an interview.
- Programme Director for the London Deanery was interviewed in three distinct capacities as: A GP trainer, Strategic Level interviewee and as a Study Planner. He has been counted only once and is included in this table in the column on GP trainers.

****Trainers Interviewed**

- Included in this figure were the trainers for 5 GP Trainees. For one GP two trainers were interviewed their current and previous trainer who had overseen their practice for approx six months since return from their overseas placement.

These interviews were used in combination with a literature review to assess what is currently known about the impact of these types of overseas initiatives for GP trainees. The literature uses the term health links for this type of initiative and is focused on NHS staff more generally rather than GP trainees.

Once the interviews were complete all interview responses and comments were reviewed and analysed. Where possible skills and competencies were matched with the RCGP framework⁶ and the Darzi model⁷

A draft report was submitted to the IHLC and the London Deanery for review on Friday 11th March before completion of the final report by 24th March 2011.

The assignment had a few constraints:

1. There was a short timeframe given to respondents to respond and take part in an interview. This was due to the short timeframe for the assignment overall. However, reminders and follow-up emails sent by the London Deanery and consultants, coupled with the genuine enthusiasm for the programme from interviewees and the rapport and goodwill developed by the consultants, along with a flexibility in scheduling and carrying out the interviews ensured a very good response rate.

⁶ Annex 5

⁷ Annex 6

FINDINGS OF SHORT FOCUSED LITERATURE REVIEW AND KEY INFORMANT INTERVIEWS

Short Focused Literature Review

The literature review included searches of internet sites such as the DH, DFID, British Medical Journal and Journal of Public Health Medicine as well as documents gathered from the London Deanery and International Health Links Centre and their partners.

The literature around NHS involvement in international health and development is scarce at the moment. The literature on the whole describes NHS involvement with staff who are already qualified health professionals, not trainees as in the OOP scheme. The initiatives described in the literature are called health links and although they are not the same as the OOP scheme they have common features, and hence the literature on this work has been used here.

Government Policy and Strategy

Policy and strategy documents from the DFID and DH have stressed the mutual benefit of health links to both the UK and developing country partners.^{8 9} In the case of the UK, benefits included personal and professional development for NHS staff and for some NHS Trusts or Boards, an international profile which helps with the recruitment and retention of staff. The UK Government believed that through health links, the UK could play its part in improving health globally while developing leadership and other skills in the NHS to improve the health and well-being of the UK population and the way we deliver healthcare.^{10 11}

Skills Developed through Working Overseas

Several studies have highlighted the benefits which working overseas can provide for NHS staff and for overseas partners^{12 13 14 15 16}. According to Banatvala and Macklow-Smith¹⁷ there are at least five areas where overseas work enhances professional development: empathy, accelerated clinical learning, a cost conscious approach to health care, taking responsibility for developing quality of care, and flexibility. Other skills include global awareness and grassroots involvement of staff in international development issues.¹⁸ Wright, Silverman, and Sloan¹⁹ believe that as developed countries struggle with limited finances, they can learn from less developed countries 'about providing effective health care for a fraction of the cost'.

⁸DFID and Department of Health. March 2008. Global Health Partnerships: the UK Contribution to Health in Developing Countries. *The Government response*

⁹ NHS, Department for Health March 2010. The Framework for NHS Involvement in International Development

¹⁰ HM Government Health is Global. March 2008A UK Government Strategy 2008–13

¹¹ NHS, Department for Health March 2010. The Framework for NHS Involvement in International Development

¹² Banatvala N, Macklow-Smith A. Career focus: bringing it back to Blighty. *BMJ* 1997;314:2

¹³ Parry E, Parry V. 1998;32:630–5. Training for healthcare in developing countries: The work of the Tropical Health Education Trust. *Medical Education*.

¹⁴ Abell C, Taylor S. The NHS benefits from doctors working abroad. *BMJ* 1995;311:133–4

¹⁵ Benjamin J Baig, Anna Beaglehole, Robert C Stewart, Leonie Boeing, Douglas H Blackwood, Johan Leuvenink and Felix Kauye. 2008. Assessment of an Undergraduate Psychiatry Course in an African Setting. *BMC Medical Education* BMC Medical Education 8:23

¹⁶ John Wright, Mike Silverman, and John Sloan. NHS Links: a new approach to international health links. *BMJ* 19 Feb 2005

¹⁷ Nicholas Banatvala and Annie Macklow-Smith. *BMJ* 1997; 314 : S2-7093 (Published 24 May 1997). Integrating overseas work with an NHS career. Is overseas work a blot on the CV?

¹⁸ John Wright, Mike Silverman, and John Sloan. NHS Links: a new approach to international health links. *BMJ* 19 Feb 2005

¹⁹ John Wright, Mike Silverman, and John Sloan. NHS Links: a new approach to international health links. *BMJ* 19 Feb 2005



For organisations, health links can provide opportunities for 'developing the workforce, nurturing and motivating staff, and championing diversity and a culture of open minds'²⁰. They can also 'motivate and energize staff, encourage ways of new thinking, and promote sensitivities to different cultures'²¹

²²In a study with twenty-two health link coordinators, thirteen of which were UK-based, the research found the top five benefits for NHS staff involved in links were:

1. Puts NHS problems in perspective
2. Develop clinical skills in a low resource environment
3. Global awareness
4. Personal satisfaction
and joint equal for number 5.
5. Experience of unfamiliar pathologies and 5. Improvements in motivation and morale

A recent study on International health links between Wales and Africa²³ found that the majority of respondents agreed or strongly agreed that their problem solving, leadership/ management and educational skills had improved. In particular, 89% of Welsh respondents agreed that their problem solving skills had improved and 74% reported they had found resource-saving ideas which were likely to directly benefit their employers and hence the people of Wales.

Interviewees made positive comments throughout about their personal satisfaction and benefits from involvement in a health link and all were committed to continuing the work in the future. These gains were mostly expressed in terms of changes in attitudes, knowledge and/or skills. The most common examples being in the areas of prioritising with limited resources, problem solving and team working.

The main skills gained were cited in terms of the soft skills such as increased confidence, organization and management, leadership and team-working. Welsh respondents felt that the benefits to the Welsh partner were clear but should be secondary to that of the African partner as the aim of their work was to improve health in the African setting.

Professional Bodies

Professional bodies such as the RCGP have also highlighted the benefits which working overseas can provide for personal and professional development of NHS staff.²⁴ The college "recognises that experience doctors gain overseas contributes significantly towards their professional development and that they return to UK general practice with enhanced clinical, organisation and managerial skills which are of great benefit to their patients, the profession and the work of the college."

20 John Wright, Mike Silverman, and John Sloan. NHS Links: a new approach to international health links. BMJ 19 Feb 2005

21 John Wright, Mike Silverman, and John Sloan. NHS Links: a new approach to international health links. BMJ 19 Feb 2005

22 Dave Baguley, Tim Killeen, John Wright MRCP FFPHM. 2006. International health links: An evaluation of partnerships between health-care organizations in the UK and developing countries 36:149-154. Tropical Doctor

23Kathrin Thomas, Jasmin Chowdhury, Hugo Van Woerden. February 2011. International Health Links: an investigation into Health Partnerships between Wales and Africa.

24 Royal College of General Practitioners. Policy statement on essential features of RCGP international programmes: Statement on overseas work experience [<http://www.rcgp.org.uk/Default.aspx?page=264>] accessed February 2011



Monitoring and Evaluation of the Impact of Health Links to NHS

There have been few attempts to evaluate programmes such as the OOP scheme and health links more generally in terms of the impact for NHS staff and their practice and the NHS as a whole. The lack of information on the impact of health links may be due in part to the challenges and constraints in measuring the impact.

Some major constraints to assessing impact of health links include:

- ‘Extremely varied nature of links’²⁵ and the complexity of measuring some of the softer skills and knowledge reported to have been acquired as a result of health links.
- Expense of objectively measuring the impact of health links²⁶
- Many health links are not formally recognised by the organisations with which NHS staff work and are not considered formally as part of their professional role thus making consideration of the impact for the NHS less important. Health links are often not considered as part of continuing and professional development programmes or appraisal for staff.
- Some believe that for too long health links between the NHS and less developed countries have been an ‘amateur pastime’²⁷

Attempts have been made to encourage and support organisations and individuals to monitor and evaluate the impact of health links^{28 29}

The government has recently given a renewed commitment to health links with the announcement in June 2010 by **DFID of a new £5 million Health Systems Partnership Fund which will enable more British health professionals to share their skills with midwives, nurses and doctors in developing countries through teaching, training and practical assistance.** This renewed emphasis by Government on international links between the NHS and overseas partners, coupled with the increased realisation by health links participants of the importance of measuring impact means that the outcome of this current study is extremely relevant and timely.

²⁵ Dave Baguley, Tim Killeen, John Wright. 2006. International health links: An evaluation of partnerships between health-care organizations in the UK and developing countries. 2006. 36:149-154. Tropical Doctor

²⁶ Dave Baguley, Tim Killeen, John Wright. 2006. International health links: An evaluation of partnerships between health-care organizations in the UK and developing countries 36:149-154. Tropical Doctor

²⁷ John Wright, Mike Silverman, and John Sloan. NHS Links: a new approach to international health links. BMJ 19 Feb 2005

²⁸ The Tropical Health and Education Trust (THET). 2008. What difference are we making? A Toolkit on Monitoring and Evaluation for Health Links.

²⁹ Department of Health. London Stationary Office. 2003. International Humanitarian and Health Work – Toolkit to Support Good Practice.



FINDINGS FROM THIS STUDY

Findings are presented from trainees, trainers and those interviewed to gather strategic information and vision for the future of the OOP. More detailed data on individual responses is provided in Annex 9.

SECTION 1: BACKGROUND DATA

A total of eight GP trainees were interviewed. Seven of these had undertaken OOP placements in South Africa and one in Sierra Leone. At the time of interview, the trainees had returned and been working in the UK from between three weeks to two years. However the majority (six) had been in the UK and working as a doctor for at least six months. The trainees had undertaken largely clinical placements with some teaching practice except for one trainee who had undertaken a medical teaching placement with some clinical emergency management. All placements apart from two had been arranged by the Deanery. All trainees received a bursary from the RCGP to cover travel costs and medical registration. Bursaries ranged between, £400 - £1,000 (UK sterling). Seven doctors received a salary whilst overseas from the host government

The motivation for taking part in the OOP ranged from some trainees having worked overseas during gap years in their undergraduate studies and wanting to go overseas again to practice medicine, having an interest in working in a developing country, wanting to broaden their skills and experience, wanting tropical medicine experience and wanting a challenge. The OOP scheme offered a structured way in which they could do this.

The OOP Process: What Worked Well

In general having a local organisation coordinating placements on the ground seemed to work well for the GP trainees. The organisation provided a good source of practical information about the country before trainees departed and whilst in-country were a local point of contact for trainees. However, this link didn't always work as efficiently as it could have done. For example one trainee received very helpful books on rural medicine from the local coordinating organisation, AHP, but received these two-thirds of the way through their placement and only received these by chance when she met AHP staff at a conference.

Having access to trainees who had been on the OOP and knew how things worked was important. For example one of the GP trainees who had completed the programme had prepared a checklist of practical steps taken in preparation for her placement and this proved useful for another trainee. This provided practical information such as when to apply for a visa and medical registration. Another mentioned how useful it was to meet trainees who had completed the OOP during their induction.

Although trainees spoke about being left to work individually, support from staff at the hospitals where they were placed was still important.

The six month de-brief with the educational supervisor in London whilst in-country to go over the e-portfolio was useful. The de-briefing sessions once back in UK were also very helpful, especially



when trainees made a presentation on their experience to their colleagues in the practices in which they were working in the UK. This was mentioned by both trainees and their trainers as being important in improving understanding. It appeared to be most effective when these presentations were conducted early in the process, when trainees joined their UK practice.

What Had Not Worked so Well in the OOP Process

This section deals with what had not worked so well with the OOP process itself i.e. induction etc.

Three trainees complained about the amount of administrative work which was required before departure which was all more time consuming than they had anticipated. This included having documents certified and visiting the embassy in person to chase visa applications.

For one trainee their post was changed two months before departure impacting on not only the trainees work plans but those of their partner. This proved very unsettling for the trainee. Lack of induction in country was raised by one trainee and having to sit RCGP exams one year earlier before they went overseas were also mentioned.

The OOP Programme: What Didn't Work so Well

This section deals with what had not worked so well with the OOP programme e.g. the actual placements

The nature of the work, dealing with high death rates and challenging ethical dilemmas, adjusting to new environment both overseas and on return to the UK. Trainees also found themselves in stressful situations feeling there was no option but to 'have a go' for example because they were on-call and there were no other staff, having to deal with the consequences of that if a patient died, and being left to supervise staff who were more qualified than they were. Obviously the nature of the work and the ethical dilemmas and to a limited extent the stressful situations, are a part of the challenge, and as such all respondents agreed that nothing could be done about this, but that it was important to highlight to people thinking of undertaking an experience like this.

SECTION 2: IMPACT ON SKILLS

In this section we record both GP trainee and trainers' responses. There were a total of eight GP trainees and a total of seven trainers. A total of six trainers commented on the skills of five individual trainees, since one trainee had had two trainers since their return to UK after their overseas placement. In addition the educational supervisor based at the London Deanery who had supervised all the trainees during their overseas placements was asked to provide comments on all the trainees more generally.

Each skill is rated against the RCGP Competency framework and Darzi model where possible. Where exact matches between the skills and the framework and model could not be made the ratings columns have been left blank.



TABLE 2: IMPACT ON TRAINEE CLINICAL SKILLS

| Responses | RCGP Competency Framework | Darzi Model |
|--|---------------------------|-------------|
| <p>GP trainee responses:</p> <p>Clinical:</p> <p>All respondents thought that their clinical skills had improved as a result of their placement. The skills mentioned most often were in relation to children and womens’ health, paediatrics, obstetrics and gynaecology, HIV/Aids, TB and minor operations. There was a sense that there was a chance to see and treat patients who would normally come under a specialist in the UK. Also a few respondents reported that simply by seeing so many patients in their hospitals and outreach clinics, they gained a lot more clinical experience than they would in the UK. Trainees on the whole had been exposed to dealing with far more complex situations and procedures than they would have been in the UK. This has meant that they became far more aware of their own skills and limitations</p> <p><i>“It was like going back to what medicine would have been 30-40 years ago in the UK, more hands on, less paperwork. There was lots of hands-on experience and opportunities to improve clinical skills.”</i></p> | 4, 5, 6 | Clinical |
| <p>Trainers’ responses:</p> <p>Clinical:</p> <p>There was a mixed view here. Some trainers reported that the clinical skills were no different from other trainees, others that the clinical skills were better and that the trainee had a broader range of skills, and one thought that their trainees’ clinical skills were overall lower than other trainees³⁰.</p> <p><i>“good mix of clinical skills because the doctor got to do far more than any of their peers at that stage of training. Learnt a lot about acute medical skills which may have taken a couple of years of general medicine in the UK. Another said you “can’t beat this type of hands on experience”</i></p> <p>An important point here is that not all the clinical skills gained were thought to be relevant or transferable to working in the UK as a GP. Trainers also believed that trainees could more easily cope with acute situations while at the same time one trainer noticed his trainee <i>‘misses simple things’</i></p> <p>The trainers believed that because trainees had dealt with so much overseas they could get over confident and this might be risky although they reiterated that this had not been the case for their trainee.</p> | 4, 5, 6 | Clinical |

³⁰ The trainee who was rated as having weaker clinical skills had only been back in the UK for 4 weeks. Nevertheless, the question asked of trainer was ‘compared with other GP trainees I would like to gather your thoughts on their: clinical and broader skills’.



Table 3: IMPACT on Generic Skills

| Responses | RCGP Competency Framework | Darzi Model |
|---|---|---|
| <p>GP trainee responses: Generic Skills All respondents thought that they had become a better doctor as a result of the OOP experience because they were much more confident in themselves in the role. The most commonly mentioned generic skills/competencies mentioned were: Confidence <i>'the confidence gained is the biggest one. It has helped me to go on and do things I might not have done'</i></p> <p>Diplomacy/ Patience</p> <p>Dealing with cultural diversity <i>'very different health beliefs and systems (overseas) and you have to learn how to get things done'</i></p> <p>Teamwork/ Partnership skills <i>'really working in a multi-disciplinary team you learn a lot'</i></p> <p>Problem solving Prioritisation especially around limited resources Having a bigger/broader perspective</p> <p>Leadership skills <i>'leadership skills improved because it is easier to get involved in management and leadership' (whilst overseas)</i></p> <p>Taking initiative/proactive</p> | <p>9, 11</p> <p>8, 9</p> <p>4</p> <p>4</p> <p>11</p> <p>8, 10</p> <p>10</p> | <p>Confidence</p> <p>Diplomacy Patience</p> <p>Problem solving Resourcefulness Personal insight</p> <p>Leadership</p> <p>Leadership/ managerial</p> |
| <p>Trainers responses: Generic skills: Decision making Dealing with uncertainly Autonomy/ Independence</p> <p>Leadership and management</p> <p>Adaptability</p> <p>Knows when to ask for help</p> <p>Good awareness of their own skills and limitations</p> <p>Communication skills</p> <p>Some trainers mentioned an increase in skill levels in management and leadership but made the point that trainees don't really get an opportunity to use these in ST3 and ST4. The majority of trainers reported that trainees were on the whole more mature and confident and better able to make decisions and take action. While most believed communications skills were more developed than other trainees one believed that communicating through an interpreter whilst overseas had lead to poorer communication skills with the use of closed rather than open questioning.</p> | <p>4</p> <p>6</p> <p>12</p> <p>8, 10</p> <p>2, 6</p> <p>4, 12</p> <p>4, 11, 12</p> <p>1</p> | <p>Problem Solving</p> <p>Independence</p> <p>Management and Leadership Adaptability</p> <p>Personal Insight</p> <p>Personal Insight</p> |



Table 4: Skills Hindered/ Potential Professional Limitations as a Result of the Programme

| Responses | RCGP Competency framework | Darzi Model |
|---|---|---|
| <p>GP trainees' responses</p> <p>Guidelines/ best practice, around UK chronic disease management <i>'formal training is difficult while you're away, you get behind on guidelines but it's not too bad to catch-up on' (when return to UK)</i></p> <p>Communication skills, as a result of trying to keep things simple because working through interpreters <i>'communicating with patients is difficult because (whilst overseas) worked with an interpreter and used closed and very focussed and direct questions.....now (in UK I) ...have to practice asking open questions'</i></p> | <p>3, 4, 5</p> <p>1</p> | <p>Clinical</p> |
| <p>Trainers responses</p> <p>Keeping up to date with NHS changes Chronic disease work and managing this over a period of time Not dealing with some health conditions Referral experience more limited</p> <p>Generally it was thought by both GP returnees and trainers that those skills needing to be re-learnt when back in UK, were not difficult to catch up on, but there needed to be an awareness that this may be an area where returnees need training in the re-adjustment period on return to UK.</p> <p>Two trainers mentioned that there could be problems in referring on, e.g. to social services, if they hadn't had the experience overseas, may be less likely to do when back in the UK</p> | <p>3, 4, 5</p> <p>5</p> <p>4, 5</p> <p>8, 9</p> | <p>Clinical</p> <p>Clinical</p> <p>Clinical</p> <p>Clinical/ Management</p> |

SECTION 3 IMPACT OF OOP ON ROLE OF TRAINEE AS A GP IN UK

Table 5: Main Changes/Benefits to UK Work as Direct Result of OOP Experience

| Responses | RCGP Competency framework | Darzi Model |
|--|--|--|
| <p>GP Trainee responses</p> <p>Confidence/ independence</p> <p>Use of resources</p> <p>More experience in paediatrics and womens' health issues</p> <p>Better at teamwork/partnership/community resources/multi disciplinary team</p> <p>Understanding of different healthcare systems</p> <p>More of an understanding/appreciation of health promotion</p> <p>A few respondents mentioned that they learnt a lot about different healthcare systems, not just in the partner country, but from other foreign doctors in the hospitals/clinics in which they worked</p> | <p>10, 12, 6</p> <p>9</p> <p>5</p> <p>8, 9</p> <p>9</p> <p>2</p> | <p>Independence, confidence</p> <p>Resourcefulness</p> <p>Clinical</p> |
| <p>Trainers responses</p> <p>More mature approach to practice</p> <p>Holistic exposure whilst working in different country allows holistic practice back in the UK</p> <p>"Doctor can tap into a wider range of possible diagnosis"</p> | <p>2</p> | <p>Clinical/ Adaptability</p> |

Table 6: Negative consequences/ limitations: GP trainee/ returnees' views

| Responses |
|---|
| <p>GP trainees' responses</p> <p>Formal training is difficult in developing countries, quite a bit of catching up to do when back</p> <p>Personal safety/health risk factors</p> <p>Can experience difficulty resettling in the UK</p> <p>Can be stressful/ difficult around basic living/logistical issues</p> <p>Can be stressful having to cover and be responsible for specialist areas when no specialist available</p> <p>"it can be difficult dealing with a lot of death and dying to then dealing with the "worried well"</p> |
| <p>Trainers responses:</p> <p>Delays entry of trainees into the job market</p> <p>Transferring skills/experience back into UK</p> |

SECTION 4: OOP – CHALLENGES/ LIMITATIONS/ BARRIERS TO BECOMING INVOLVED

This section assesses the challenges, limitations and barriers to becoming involved in the OOP. The responses of strategic level interviewees, trainers and trainees are all recorded here.

CHALLENGES OF THE OOP

Interviews with those working at a more **strategic level** identified the following challenges to the OOP at an organisational level:

- OOP can be disruptive to financial planning for a Deanery. A Deanery plans to be able to take a trainee once they return but in effect 'you are taking a risk because funding is not yet guaranteed for the year in which the trainee will return'. Not so much an issue currently since numbers involved in OOP are small but it could be in the future if numbers increase.
- Maybe disruptive to a GP practice e.g. usually a GP practice knows it is getting trainee X, if trainee X decides to do OOP their placement needs to be deferred. However this is no different than dealing with maternity leave.
- The cost of getting all staff together to undertake selection interviews for OOP placements is expensive. This may be slightly different for London Deanery because they have secured funding for a Programme Director who arranges and oversees this process.

TRAINER RESPONSES -TRAINERS' VIEWS OF LIMITATIONS OF THE OOP PROCESS

- Possibility that trainees pull out at late stage e.g. one of the trainees pulled out and cannot fill the place now. There must be some way of assessing attitude of trainees earlier and getting them to realize the serious commitment they making to the programme.
- Would be useful to up-skill the trainees in the diseases of the region they are going to.
- Can be disruptive to training, re-adjustment and how to use the skills learned.
- May have been better to do de-brief with trainee about their OOP experience earlier.
- It's important to look at how trainees will use the experience they have gained (if at all) and slot back into general practice.

BARRIERS TO INDIVIDUAL TRAINEES OF BECOMING INVOLVED IN OOP

Trainers, trainees and those working at a strategic level all stated very similar barriers to trainees becoming involved in the OOP.

- Disturbs and interrupts training
- Personal reasons including partner, financial commitments e.g. mortgages (, pension payments etc, but trainees need to know about these practical issues/solutions to them.
- Trainee may be worried about what would be expected from them in-country.
- How it fits in with their other GP training and the regulations and rules surrounding the OOP. It was believed that accreditation could be useful.

SECTION 5: RECOMMENDATIONS for IMPROVING THE OOP PROCESS

We asked trainers and trainees to provide recommendations for improving both the OOP process e.g. recruitment, selection and the OOP placement itself.³¹

GP Trainee Responses: Improvements to programme

- Having a partner organisation on the ground is useful to provide trainees with clear idea of conditions overseas but need to ensure this works more effectively for all trainees (see points below).
- Both information and assistance with the practical aspects of settling overseas and information relating to professional practice are important. For example:
 - Crash courses in diseases prevalent in partner country (e.g. HIV/TB).
 - Guideline books are very good, but would have been more useful earlier in process
 - Information relating to buying a car locally, transferring money to UK when leaving overseas placement.
- Streamline paperwork if possible.

Recommendations from GP Trainees in terms of making the most of the year/what helped them most:

- Going with a partner/ another trainee attending the same hospital provided good support
- Get involved as much as possible in the community

Recommendations for Improvements to Programme: Trainers' Responses

- Up-skill the trainees to diseases of the region they are going to
- De-brief with trainee about the OOP experience sooner rather than later. Both GP trainers and trainees found the experience of GP trainee presenting on their experience overseas extremely useful in helping everyone's understanding.
- Programme should be advertised more widely, and opportunities made available to GPs currently in practice (not just trainees) and the process for doing this should be made simpler e.g. getting cover for practice whilst overseas.
- Preparing for practice back in the UK may be one thing that needs to be incorporated on the OOP process to help doctors settle and determine early on how they are going to use the skills they have learnt

³¹ Other comments received while finalising this report included

- Pre-deployment preparation e.g. undertaking DTM&H would prepare trainee for work overseas and would also be relevant to practice in UK especially if working in practice with high immigrant/ethnic minority populations.
- If OOP trainee salary is paid by overseas institution and there are clear benefits to UK could pre-deployment training e.g. DTM&H be subsidised?
- better definition of roles and responsibilities to be expected on specific placement well in advance would assist in appropriate preparation.
- As OOP scheme becomes established preparation can be staged over time prior to overseas placement. this might even include basic language training.

Recommendations for Improvements to the OOP Process -

- Advertising for the OOP scheme begins in year one but recruitment takes place near the end of year two. Start recruiting earlier to give trainees more lead in time however, there is a concern that recruiting earlier may mean that more trainees are lost due to drop-out.
- Provide a longer period to trainees to decide whether to accept or decline their placements. A period of one month was suggested.
- One trainee has recently pulled out of the OOP just a few months before the OOP placement was due to begin. To prevent this it was recommended that all trainees understand the seriousness of the commitment which they are making to undertake this placement from the outset, and once committed they have a post which cannot easily be filled at short notice if the trainee is to suddenly pull-out from the scheme.
- Track trainees and interview them again in two years time to see what they are doing – how have they adapted, are they initiating services, ideas, setting-up services from scratch, showing better use of NHS resources etc?

Recommendations more generally for the OOP

- A more in depth study of the e-learning logs which contain competency areas
- Maximise the OOP training experience and plan how learning will be incorporated into practice in the UK. Get trainees to prepare for practice back in the UK before they return. This aspect could be added to the OOP process at several stages: briefing trainees before departure, discussing at the six month assessment and at initial de-briefing session when trainees return. At each stage ask trainees to consider how they plan to incorporate their skills. It is anticipated that this will not be an easy task, the nature of the work being very different, but raising awareness may prove effective in getting the trainee to anticipate being back in the UK and the NHS system
- Make research an integral part of the OOP in future not an add-on. Undertake standardised questionnaire with trainees before they go out. It is suggested that a rating scale be given to trainees to complete before their placement and after their return on those dimensions that are considered important for the trainees' development.

SECTION 6: CONCLUSIONS, STRATEGIC VISION and NEXT STEPS FOR THE OOP

There seems to be little doubt that the OOP scheme does provide GP trainees with an excellent opportunity to develop their clinical skills and more generic skills such as leadership, management and decision making as well as effective use of resources.

Our findings show that there is an increase in skill levels reported by both trainees and trainers, in the more generic competencies particularly in the “Excellent domain” of the RCGP Competency Framework and in the soft skills area of Darzi model³². It is worth noting that although clinical skill improvements are not always directly transferable to UK practice, the simple fact that GP trainees had been exposed to a greater volume and breadth of hands-on experience than their peers, seemed to have an overall impact on their confidence to make effective decisions in their clinical practice in the UK.

There is little doubt that the skills gained overall are beneficial and transferable to the NHS, and would provide evidence to support that providing GP trainees with an opportunity to work in complicated, poorly resourced and challenging environments has the potential to strengthen the generalist/ specialist interface and equip GP trainees to become future leaders within their profession.

During interviews with more strategic focussed interviewees it was important to capture the vision for the next steps of the OOP and how this model may be best used in future.

The London Deanery sees one of the main roles of their programme as being a **model** and **seed** for other Deaneries, providing a model of best practice.

³² Both the RCGP Competency Framework (Annex7) and Darzi model (see Annex 8) were used to rate skills developed by trainees. The Darzi model is a framework which was developed to assess NHS health professionals skills in International Development we have called this the Darzi model throughout the report for ease of reference. The full title given to the model is Tribal Newchurch adaptation of Lord Darzi's Next stage review(2009)



Interviews with Deanery and RCGP colleagues in Scotland revealed that they were already keen to work with and replicate the model which had been developed by the London Deanery. In fact they were in the process of recruiting two of their own GP trainees for OOP placements which had been given to them by the London Deanery.

- The London Deanery model and the OOP scheme more generally was seen as very beneficial e.g. some of the skills required of the doctors of the more remote and rural parts of UK e.g. highlands and islands of Scotland are not unlike those required in rural hospitals in Africa, e.g. in terms of minor surgery, child delivery and general requirement for doctors to deal with perhaps more acute situations which may usually be dealt with at a hospital. Experience of OOP could provide an incentive for doctors to work in these more remote areas.
- It has been suggested that there could be specialist training for GPs such as a rural fellowship or training and the OOP could be part of this.
- RCGP and the Deaneries have been lobbying government for an extension to GP training from three to four years. To date the resources for this type of expansion have not been forthcoming. The OOP would fit very well as part of a four year GP training programme particularly since the costs of implementing OOP would appear to be minimal. .
- The OOP is an excellent way of responding to the Crisp³³ report as part of the NHS response to the global health agenda
- The GP OOP model is transferable to other specialities within Deaneries e.g. paediatrics, obstetrics and gynaecology
- Although attempts have been made to work with VSO previously, further attempts and opportunities should be sought for the future to work more closely with organisations such as the International Health Links Centre, Health Bay, the Tropical Health and Education Trust (THET) and VSO. One of these organisations could potentially hold a repository/ bank of posts available to Deaneries.
- RCGP and its Junior International Committee could get more involved in promoting the OOP.
- Deaneries may need to look at funding or at least the resources in terms of time for developing OOP. The London deanery has one partly funded Programme Director post to oversee OOP.

Although the current study is small the small sample size allowed more in-depth data to be gathered on the impact which the OOP had on GP trainees skills and how this was already impacting on their practice in the UK. In most cases the skills recorded as part of this assignment were mapped with the RCGP competency framework and the Darzi model. The fact that the OOP scheme develops skills and competencies required of GP trainees seems to provide evidence of the role which this model could play in GP training in the future.

Furthermore, the fact that the OOP is a well structured programme which follows the Gold Guide *Reference for Postgraduate Specialty Training in the UK*³⁴ and is already linked to continual learning through e-portfolios means that it is well placed to potentially be used as a model and form part of GP training in the future. The discussion points raised above serve to clarify the benefits/ potential of further expanding and improving this initial vision.

³³ Lord Crisp, Feb 2007. Global Health Partnerships. The UK contribution to health in developing countries

³⁴ Gold Guide Reference Guide for Postgraduate Specialty Training in the UK.34 Section 6.65 to 6.91 Modernising Medical Careers website www.mmc.nhs.uk. Accessed February 2011



ANNEX 1 Terms of Reference

An evaluation of a General Practitioner Time out of Program scheme: impact on trainee's competencies and skills

1. Background

The International Health Links Centre (IHLC), hosted at Liverpool School of Tropical Medicine, was established in 2009 with funding from DFID. The goal of the IHLC is to enhance access to health care in the developing world by promoting international partnerships that will increase the number and skills of the health workforce.

The primary role of the International Health Links Centre is to act as a Resource Centre. The Centre will act as a “one stop shop” resource centre for individuals or institutions looking at forming links. The Centre will provide independent advice and guidance to potential developers of links and existing links on the technical and administrative aspects of establishing and maintaining links. Members will have access to various resources including a searchable database, discussion forum and other resources which are appropriate to both UK and international organisations which will assist them in developing their link.

An additional function of the IHLC is to carry out evaluations of existing links, both within the DFID/DH funded programme and beyond. Comparative analyses of UK links with international practice will also be done.

The data generated will be used to highlight evidence based best practice, as well as form guidance on administration of links. The data will also enable the Steering Committee and other relevant stakeholders to derive lessons learned for the future development of the programme.

The Centre will evaluate a General Practitioner Time Out of Program (OOP) scheme that is currently offered by the London Deanery to its GP trainees. The OOP is used to enhance GP clinical experience and to encounter different working practices and also encourages educators to facilitate training and work experience overseas. The OOP serves as an opportunity for excellence and anticipates that the experience provided by OOP enhances a number of competencies, such as building GP trainee's confidence and consolidating and developing clinical, managerial, leadership, cultural and educational skills, many of which are beneficial and transferable to the NHS. Working in complicated, poorly resourced and challenging environments has the potential to strengthen the generalist/specialist interface and equip GP trainees to become future leaders within the profession.

The London deanery has built a menu of overseas OOP posts in developing countries with in-country partner agencies. The posts are inspected, quality assured and facilitated by the Deanery and offered to GP trainees. Sixteen GP trainees have taken up these posts since 2009.



2. Objective

The objective is to evaluate the OOP scheme in terms of:

- What are the impacts of the OOP to GP trainees' clinical skills
- What are the impacts of the OOP to GP trainees' decision making, management and leadership skills
- What additional competencies (personal or professional) does the OOP provide?
- What impact has the OOP had on the GP trainees' practice in the UK?
- What are some of the limitations of OOP scheme

3. Specific tasks

- A. Design an evaluation framework that will inform for the OOP scheme
 - Literature review on similar schemes run by other royal colleges in the UK/ overseas
 - Evaluation framework to mirror current NHS/ RCGP competency frameworks
- B. Carry out Evaluative surveys and interviews
 - Administer interviews to GP trainees
 - Contextualise and collate emerging themes from GP trainees' e-portfolios
 - Initial analysis of results
- C. Reporting on findings
 - Prepare summary documents of evaluation results
 - Provide initial analysed results

4. Time frame

Timeframe for delivery of the tasks will be agreed with the consultant.

5. Person Specification requirements for position:

Academic

- Educated to Masters level

Experience

- Qualitative methods
- Evaluation studies
- Work in developing country health system (desirable)

Knowledge

- Understanding of developing country health systems
- Understanding of NHS clinical and management systems (desirable)

6. Administrative arrangements

The consultant will work directly with the IHLC Project Manager, who will be responsible for feedback and final submission of outputs. The consultant will work remotely from LSTM.

7. Budget

Budget justifications should be agreed. There is a financial limit of £4,900. Consultants travel expenses will be reimbursed (when accompanied by receipts were applicable).



ANNEX 2: LIST OF INTERVIEWEES

| Name | Designation | Organisation |
|-----------------------------|--|---------------|
| Dr Alfansa Bhuiya | GP Trainee within London Deanery | NHS |
| Dr Eric Britton | GP Trainer Programme Director rat St Marys within London Deanery | NHS |
| Dr Neera Dholakai | GP Trainee London Deanery | NHS |
| Dr Sara Evans | GP Trainer London Deanery | NHS |
| Dr John Gillies | Chair of Scottish Council RCGP Scotland | NHS |
| Professor Arthur Hibble | Director of Primary care and Development Retired Dean of East of England | Anglia Ruskin |
| Dr Deyo Famuboni | GP Trainee London Deanery | NHS |
| Dr Sarb Kaler | GP Trainer within London Deanery | NHS |
| Professor Anthea Lints | Director of Postgraduate GP Education Scottish Deanery and Former Director of Postgraduate GP Education London Deanery | NHS |
| Dr Patrick Kiernan | Programme Director Time Out of Programme General Practice Department London Deanery | NHS |
| Dr Kwalombota Kwalombota | Project Manager International Health Links Centre (IHLC) Liverpool School of Tropical Medicine | IHLC |
| Dr Tim O'Dempsey | Senior Lecturer, Clinical Group and Director of the IHLC | LSTM |



| | | |
|----------------------|---|-----|
| Dr Zoe Pinto | Liverpool School of Tropical Medicine (LSTM) GP trainer within the London Deanery | NHS |
| Dr Adrian Richardson | GP Trainer within the London Deanery and Clinical Lead NHS Connecting for Health | NHS |
| Dr Kim Rollinson | GP Trainee London Deanery | NHS |
| Dr Lauren Rosenberg | GP Trainee London Deanery | NHS |
| Dr. Caroline Scott | GP Trainee London Deanery | NHS |
| Dr Mark Spencer | GP Trainer London Deanery | NHS |
| Dr John Spicer | Director of GP Education and Head of School London Deanery | NHS |
| Dr. Emily Spry | GP Trainee London Deanery | NHS |
| Dr Joanna Thorne | GP Trainee London Deanery | NHS |



ANNEX 3: REFERENCES AND DOCUMENTS USED

Abell C, Taylor S. The NHS benefits from doctors working abroad. *BMJ* 1995;311:133–4
Attwood, D (2009) Out of programme experiences and their impact on medical education: A report on the visit of Drs David Attwood and James Ayrton from St Mary's Hospital, Isle of Wight to Juba Teaching Hospital, Southern Sudan.

Lord Crisp. Feb 2007. Global Health Partnerships. The UK contribution to health in developing countries

Dave Baguley, Tim Killeen, John Wright. 2006. An evaluation of partnerships between health-care organizations in the UK and developing countries. **36**:149-154. *Tropical Doctor*

Dr. Benjamin J Baig. Scotland Malawi Psychiatry Project

Banatvala N, Macklow-Smith A. 1997. Career focus: bringing it back to Blighty. *BMJ* 314:2

Nicholas Banatvala and Annie Macklow-Smith. *BMJ* 1997; 314 : S2-7093 (Published 24 May 1997). Integrating overseas work with an NHS career. Is overseas work a blot on the CV?

Department of Health. October 2004. The NHS Knowledge and Skills Framework and the Development Review Process

Department of Health. London Stationary Office. 2003. International Humanitarian and Health Work – Toolkit to Support Good Practice.

Department of Health. 30 June 2008. A High Quality Workforce NHS Next Stage Review

DFID and DH. March 2008. Global Health Partnerships: the UK Contribution to Health in Developing Countries. *The Government response*

Dr Andrew Furber. Department of Health. 2005 Survey of International Health Links of English NHS Trusts

Gold Guide *Reference Guide for Postgraduate Specialty Training in the UK.*¹ Section 6.65 to 6.91
Modernising Medical Careers website www.mmc.nhs.uk. Accessed February 2011

HM Government Health is Global. March 2008. A UK Government Strategy 2008–13

John James, Chris Minett, Liz Ollier. May 2008. DFID Resource Centre Evaluation of links between North and South Healthcare Organisations.

NHS, Department for Health March 2010. The Framework for NHS Involvement in International Development

Parry E, Parry V. 1998. Training for healthcare in developing countries: The work of the Tropical Health Education Trust. *Medical Education*, 32:630–5.

Royal College of General Practitioners. Policy statement on essential features of RCGP international programmes: Statement on overseas work experience
[<http://www.rcgp.org.uk/Default.aspx?page=264>]

Kathrin Thomas, Jasmin Chowdhury, Hugo Van Woerden. February 2011. International Health Links: an investigation into Health Partnerships between Wales and Africa.

The Tropical Health and Education Trust (THET). April 2010. Developing Global Health Link Partnerships to improve Health Capacity in Developing Countries THET response to the end of programme evaluation report for DFID's Civil Society Challenge Fund



The Tropical Health and Education Trust (THET). Informal paper produced by Anna Downie, June 2010. Monitoring and Evaluation for health Links. Evaluating the impact of the health Link on the UK Partner

Tribal Newchurch. July 2009. Towards a NHS Guidance Framework for UK Health Sector Involvement in International Development –Consultation Paper

John Wright, Mike Silverman, and John Sloan. NHS Links: A New Approach To International Health Links. BMJ 19 Feb 2005



ANNEX 4: INTERVIEW SCHEDULES

INTERVIEW SCHEDULE (IS) FOR GP TRAINEE RETURNEES

Background Data for GP Returnees

At what stage of your GP training did you undertake your OOP?

Where did you go?

How long was your placement?

What was the nature of your placement?

- Clinical practice
- Research
- Teaching
- Other. Please specify

Please specify any sources of funding that you received?

Following your OOP placement how long have you been working back in the UK as a doctor?

Prompt for Interviewer.

Please remember to gather specific examples of evidence of skills where possible throughout the IS.

SECTION 1: Motivation for Taking Part in OOP and Process of the OOP

1. a) What was your motivation for undertaking your placement
- 1 b) I would like to explore the process of your placement.

In particular I would like to explore:

What worked well?

What didn't work so well and what could have helped?

Interviewer Prompt:

*Prompt interviewee to comment on **each stage of the process** for their OOP placement: **Promotional process** (when did you first become aware of/ potentially interested in the idea); **Recruitment process**; **Pre – Induction**; **Induction** (in Durban – or otherwise depending on host country); **De-briefing on settling back into the UK**; **Post de-briefing** – 3months+*



SECTION 2: Impact of OOP on GP Trainee Skills

2. I would like to focus now on your OOP experience in a developing country and in particular the impact this had on your skills. I would like to know **which skills** you believe you developed most, which skills were hindered, which remained unchanged and **which aspects of the OOP** do you think have contributed to this.

Interviewer Prompt:

*Interviewer to check for **clinical** and more **general skills** e.g. decision making, management and leadership and **any additional skills** (personal or professional)*

SECTION 3: Direct Impact of OOP on Your Practice in the UK

3. I would now like to focus on the direct impact your OOP experience has had on your practice as a doctor working in the UK

3. a) Which **3 main changes** have you made to your NHS work in the UK as a direct result of your OOP experience?

Interviewer Prompt:

Interviewer to check for changes wider than simply clinical skills e.g. organisational developments, changes to personal ways of working

3. b) Comparing your practice prior to your OOP placement and now, what might your patients say was different in your practice?



SECTION 4: OOP in Developing Country General Question on benefits, limitations, the OOP process and barriers to becoming involved in OOP

4. a) Looking at your whole OOP process from start to finish what 3 main suggestions for improvement could you make for the programme.

4. b) What have been the 3 main benefits to you and your practice of the OOP?

Interviewer prompt:

e.g. any positive consequences of being involved in OOP e.g. to their career, financially?

4. c) What have been the 3 main limitations to you and your practice of the OOP?

Interviewer prompt:

e.g. any negative consequences of being involved in OOP e.g. to their career, financially?

4. d) What do you believe are the main barriers to trainees becoming involved in OOP in developing countries

Interviewer prompt:

e.g. time, clear guidance from your professional bodies, funding



INTERVIEW SCHEDULE (IS) FOR GP TRAINERS

INTRODUCTION

We would like to explore the impact of OOP on GP trainees practice on return to the UK. We are keen to explore if there are any differences in the skills of these GP trainees versus GP trainees who have not been involved in an OOP placement in a developing country.

Prompt for Interviewer.

Please remember to gather specific examples of evidence of skills where possible throughout the IS.

SECTION 1: GP Trainee Skills

1. Compared with other GP trainees I would like to gather your thoughts on their:

- 1. a) clinical skills
- 1. b) broader skills

Interviewer prompt:

e. g. decision making, management and leadership skills

- 1. c) additional professional skills

Interviewer prompt which relates to questions 1. a) – c):

Where are they showing greater level of skills? Are there skills gaps? If so, in which areas? What do you think might help address any gaps?)

SECTION 2: GP Trainee Practice in the UK

- 2. a) In your opinion, what are the **3 main benefits** to the trainee's role as a GP in the UK

Interviewer Prompt:

Interviewer to check for potential benefits to patients and the wider practice in which the GP works

- 2. b) In your opinion, what are the **3 main limitations** for the trainee's role as a GP in the UK

Interviewer prompt:

Interviewer to check for any potential negative consequences to patients and the wider practice in which the GP works



INTERVIEW SCHEDULE (IS)

BACKGROUND, CONTENT and FUTURE of OOP

STRATEGIC LEVEL

SECTION 1: Background on OOP and the OOP process

2. a) What was your motivation for developing the OOP placements in developing countries?
- b) I would like to explore the process of OOP. In particular I would like to explore:

What is working well?

What is not working so well and how are you planning to remedy this?

Interviewer Prompt:

*Prompt for more information at each stage of the OOP process: **Promotional process; Recruitment process; Pre – Induction; Induction** (in Durban – or otherwise depending on host country); **De-briefing** on settling back into the UK; **Post de-briefing** – 3months+.*

SECTION 2: Content of OOP and Barriers to Becoming Involved in OOP

3. a) I would like to focus now on the design and content of the OOP experience. Can you describe this?

Interviewer Prompt:

e.g. Are the aims and objectives of each programme where GP trainees are placed aligned with the health policy and strategy of the government in the partner country e.g. South Africa? Are the objectives for each trainee agreed in advance? More generally what is working well, what is not working so well and how could the OOP content be improved?

2. b) What do you believe are may be the main barriers to **trainees** and **organisations** becoming involved in the OOP in developing countries?

SECTION 3: The Future of the OOP

3. a) What is your vision for the OOP moving forward?

Interviewer Prompt:

What are the barriers to achieving this? What are the resources required?

What are the implications for professional bodies such as RCGP? What are the implications for GP training? What are the implications for the NHS as a whole?



ANNEX 5: RCGP COMPETENCY FRAMEWORK

1. **Communication and consultation skills:** this competence is about communication with patients, and the use of recognized consultation techniques.
2. **Practicing holistically:** the ability of the doctor to operate in physical, psychological, socioeconomic and cultural dimensions, taking into account feelings as well as thoughts.
3. **Data gathering and interpretation:** the gathering and use of data for clinical judgment, the choice of physical examination and investigations, and their interpretation.
4. **Making a diagnosis / making decisions:** this competence is about a conscious, structured approach to decision making.
5. **Clinical management:** the recognition and management of common medical conditions in primary care.
6. **Managing medical complexity and promoting health:** aspects of care beyond managing straightforward problems, including the management of co-morbidity, uncertainty, risk and the approach to health rather than just illness.
7. **Primary care administration and IMT:** the appropriate use of primary care administration systems, effective recordkeeping and information technology for the benefit of patient care.
8. **Working with colleagues and in teams:** working effectively with other professionals to ensure patient care, including the sharing of information with colleagues.
9. **Community orientation:** the management of the health and social care of the practice population and local community.
10. **Maintaining performance, learning and teaching:** maintaining the performance and effective continuing professional development of oneself and others.
11. **Maintaining an ethical approach to practice:** practicing ethically with integrity and a respect for diversity.
12. **Fitness to practice:** the doctor's awareness of when his/her own performance, conduct or health, or that of others, might put patients at risk and the action taken to protect patients.



ANNEX 6: The Framework for NHS Involvement in International Development³⁵

Benefits to NHS staff

Individual health professionals - clinicians and managers can gain a great deal from opportunities to work and train overseas. A Voluntary Service Overseas (VSO) survey concluded the 80% of returned management professionals believed they gained expertise that they would not have been able to get in the UK.

'NHS employees are characterised by a powerful sense of vocation and a desire to improve the health and wellbeing of communities. The opportunity to provide support to healthcare systems and communities in developing countries helps reinforce these values, offers rich scope for professional development and the satisfaction of a meaningful personal contribution. The NHS employer usually welcomes back a highly motivated member of staff who has grown personally and professionally, to deliver better services for patients in the UK. In this sense, there is a strong business case for NHS employers.'

NHS Confederation

Working in complicated and challenging environments assist healthcare professionals consolidate and develop a range of hard and soft skills such as clinical, managerial, leadership cultural and educational skills (see Figure 1), which are beneficial to and transferable to the NHS.

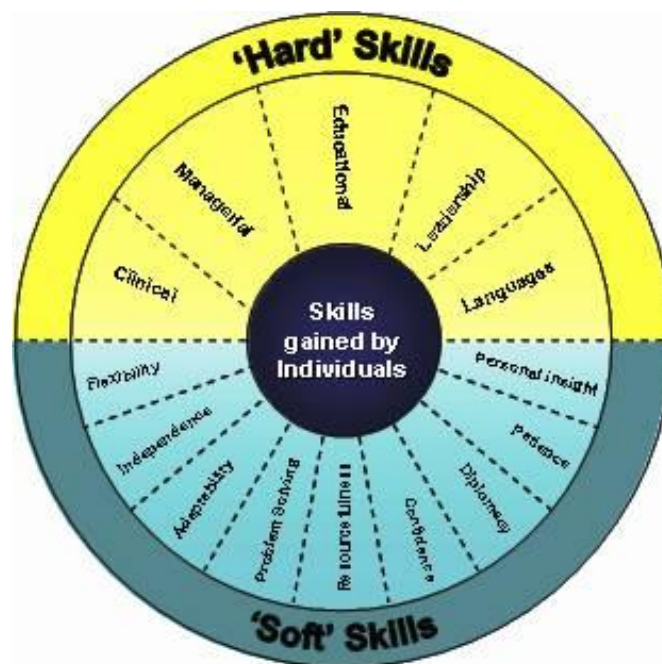


Figure 1: Skills gained by individual health workers
Tribal Newchurch adaptation of Lord Darzi's Next Stage Review (2009)

³⁵http://ihc.org.uk/Framework/benefits_staff.htm