Workplace-Based Assessment for GP Specialist Trainees in Hospitals – Part B: What are the views of hospital-based assessors of WPBA?

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Background to Part B

In Part A of the project it was revealed that there were a number of weaknesses in the way WPBA was working for trainees during their hospital posts, which undermine the potential value of assessment in improving performance of GP STs. These weaknesses focused on the quality of feedback given, particularly written feedback which was often felt to be cursory and superficial; a perceived lack of openness between colleagues such that mainly positive feedback is received, and overall, a 'tick box' approach that limits the perceived validity of judgments within WPBA. Each of these issues involves the assessors and a number of the suggested solutions implicated changes for assessors hence it was deemed important to seek the participation of assessors in the evaluation.

There is some support for these findings in the literature that has subsequently emerged, including evidence that assessors working with GP STs have difficulty giving 'negative formative feedback' to trainees, especially when this is face-to-face, leading to leniency, and similarly found the box ticking approach limited the extent of professional judgements in assessment.[1] From their study, Makris et al (2010) called for further investigation of the barriers to giving negative feedback, to maximise the educational experiences in hospital posts, which further informed the aims for this study.[1]

Although there is still only a limited literature relating specifically to the context of general practice training, there is evidence from other specialities that assessors face particular challenges in adapting to their new role. A survey of psychiatrists found that assessors lack confidence in using the tools within WPBA and that more training is needed.[2] Among surgical assessors, there is evidence of dissatisfaction with a similar system of assessment[3] and beyond the UK, research among anaesthetists in a pilot of the new scheme in New Zealand found that assessors demonstrate a cursory approach at times and lack of understanding of the scores, they are uncomfortable with lower scores and negative feedback, and perceive the threat to the specialist-trainee relationship.[4]

Despite the doubt such evidence inevitably casts over the implementation of WPBA,

the adoption of competency-based performance assessment within postgraduate medical education continues apace. Such a widespread shift in postgraduate education culture can be seen to reflect societal demands for greater transparency regarding the content of postgraduate training and performance of doctors.[5] Similar systems are evolving in Australia and New Zealand mentioned above, The Netherlands and Denmark, with the UK experience serving up some of the lessons learned about implementation.[6] Nonetheless, this change is occuring without a solid foundation of evidence about the best way to implement such a complex system or indeed about the benefits of such activity on doctors' performance[7,8] and the problems emerging in this and other studies warrant further enquiry.

Aims of the study

Part B of the study aimed to establish the views of hospital-based assessors involved in assessment of GP trainees, with the following specific questions arising from Part A of the study and relevant literature:

- What do consultants find useful and challenging about WPBAs for GP trainees?
- What is the best way for consultants to learn about assessment?
- What is the best way to help assessors undertake high quality WPBAs for GP trainees?
- How feasible would the role of a lead assessor be, to support WPBAs in hospital posts?

A number of sub-questions further guided the study:

1. What do assessors value about WPBAs and what do they not value?
2. What are the most challenging parts of being an assessor?
3. How do consultants find assessing doctors training in General Practice?
4. How important is time for the role? And recognition for the role?
5. What are consultants views/experiences of training in assessment? What would be the best way for consultants to learn about how to do good quality WPBAs?
6. How could assessors be better supported with assessment?

7. What could the responsibilities of a ‘lead assessor’ include? How feasible is this role?

Funding/Advisory board

Part B of the study was also funded by the Severn School of Primary Care, Severn Deanery. The project manager was Abigail Sabey (lead researcher and report author), Senior Lecturer, UWE who carried out the work in conjunction with Dr Michael Harris, Associate Dean, Severn School of Primary Care (co-author). The work was supported by colleagues Dr Pam Moule and Dr Pat Young from the Centre for Health Services Research at UWE, and overseen by an advisory board of academic and GP colleagues chaired by Dr Pat Young, Senior Lecturer, UWE.

Ethics approval

The study was approved by the UWE Faculty Research Ethics Sub-Committee in May 2010. NHS ethics approval was not required on the grounds that the study was an educational evaluation.

Methods

Given the aims of Part B of the evaluation were to seek the views of hospital-based assessors and their role in assessing GP trainees, and the individual nature of their experiences, a qualitative approach was deemed the most suitable to access such views.[9] It was anticipated that the potential participants could be hard to access and so a flexible approach to data collection was needed to maximise the participation of busy, senior medical colleagues. Individual interviews would be sought but if an existing meeting offered an opportunity to convene a focus group that would be taken, with both methods being appropriate to capture in-depth views of assessors.

Sampling

Assessors were drawn from three of the five centres falling within the Deanery, including both centres involved in Part A and an additional centre to widen the potential pool of participants. The initial approach to sampling was purposive in that only assessors involved in WPBA with GP trainees would be included and from a range of relevant specialties. The Directors for Medical Education (DME) in each centre were approached in September 2010 to gain their support for recruitment and help identify the relevant individuals. The response from each centre was variable, with one DME failing to respond at all, and of those who replied different approaches were offered. Three DMEs enabled direct access to consultants by the researcher and the other chose to make the contact themselves and invite responses. This had a distinct effect on the success of the sampling with the centres allowing direct contact yielding the majority of responses. It should be acknowledged therefore, that the sampling was also in part a volunteer sample, and carries the potential for bias associated with such an approach in that we cannot know if those consultants who volunteered are typical of those who did not. In all three centres response from assessors was slow and repeated attempts to recruit participants were necessary. Where direct access was possible, email was used to invite participation with up to three reminders being sent. A number of attempts to boost numbers from the two centres having lower participation were made in February 2011 and following the final two interviews recruitment ceased on the grounds that the data obtained from

the 15 participants showed a high level of consistency within the key themes of the interviews.

Data collection

In the event, no existing groups or events gave the opportunity to offer a focus group and all participants were interviewed individually by the lead researcher. A participant information sheet (see Appendix A) was sent to all respondents in advance. Interviews were done by telephone as this offered the most convenience to participants being easy to arrange and fit in to a busy schedule. This methodology worked particularly well and the researcher noted the quick rapport established with all participants and the ease of the conversation which was attributed to all participants being well used to conducting all types of conversations by telephone in their work and being comfortable with this medium. A topic guide was used by the researcher as a checklist of items to raise in the conversation (see Appendix B) but the conversation was allowed to flow with the guide acting as a checklist of items raised. In keeping with a semi-structured approach a flexible stance was taken, with participants also raising their own topics enabling the interview to capture additional themes of relevance to the participants and adding depth to the study.

Consent was obtained from all interviewees prior to the start of the discussion. The interviews lasted between 20 and 35 minutes and were recorded using a digital recorder. Data were transcribed verbatim by experienced transcribers from the Faculty research admin team. All transcripts were anonymised and data stored securely.

Analysis and results

Analysis of interview data

Prior to the analysis of the qualitative data, the transcripts from the fifteen interviews were read and checked for accuracy against the audio copy. This was undertaken by the lead researcher as soon as transcripts were received to aid recall of the discussion and a number of corrections were made to improve accuracy of the data. A thematic framework analysis of the data as described by Ritchie et al (2003),[10] was

then undertaken beginning with the process of identifying initial themes and concepts to form a suitable index for the data. Consistent with the framework approach, this initial process was informed by the topics raised by the interviewer as well as those introduced by the interviewee. This preliminary index was then sorted into main and sub-themes until a workable structure was achieved although this would develop and refine as the analysis progressed. The next stage was to apply the initial framework to the data. To begin, six transcripts were 'indexed' by the researcher and to add rigour, two of these were indexed separately by an experienced researcher from the Deanery research team to allow comparison between the researchers. Two minor revisions were made to the sub-themes in the framework following this. During the application to the remaining data set further refinements and additions were made to the framework consistent with this approach to analysis[10] and the final analysis resulted in nine main themes. The process of analysis was facilitated by the use of the software package QSR Nvivo version 8.0.

Findings

Of the 15 consultants who took part in the project, 8 were male and 7 were female. The specialities of assessors were wide-ranging including many of the key primary care rotations: obstetrics and gynaecology, psychiatry, ENT, general medicine and care of the elderly, paediatrics, neurology, orthopaedics, emergency care, renal and palliative medicine.

The findings from Phase 2 are described below under the following headings: what assessors value in WPBA; what assessors find challenging and detracts from the value of assessment; what issues arise from working with GP trainees in particular; the role of training in assessment; how quality can be improved in assessment.

Quotes from assessors are used selectively in this account where they are felt to illustrate the theme described or to give a flavour of the strength of feeling. The quote will be identified as originating from either a male or female assessor, their participant identifier to demonstrate the range of people quoted, and their centre (A, B or C). Speciality will not be given as this could threaten the anonymity of participants. Other abbreviations used in this account are names of the assessments used in WPBA, as follows:

DOPS = Direct Observation of Procedural Skills

Mini-CEX = Mini Clinical Evaluation Exercise

CbD = Case-based Discussion

MSF = Multi-Source Feedback

1. What assessors value in WPBA

1.1 WPBA gives a mandate for feedback and makes it happen

Assessors value the system of WPBA as a whole because it formalises a process that might not otherwise happen and in this way legitimises the need to spend time with a trainee, which carries the implication this might otherwise be difficult to achieve:

> "..they are better than sort of winging it really which is what we did traditionally…there was no real formalised assessment of whether they were good, bad or indifferent, there wasn't really any meat on it. So that I think is quite useful..to be able to sit down with the trainee and discuss what they're doing and what they've done." (Male, P6, Centre B).

> "..it gives an opportunity to sit down with the trainee and spend a little bit more time with them.." (Male, P4, Centre A)

> "And it actually gives you an excuse to block out a whole block of time in your diary and say 'No, I'm sorry, I'm with my GP trainee today and we're going to be working together and we're going to be doing lots of teaching together and a bit of a session together and it's fab. I really value that because otherwise I think it would be so easy to just not end up doing it properly." (Female, P14, Centre C).

Some also suggested that it provides 'a mandate' for giving feedback which avoids the "feeling that they're being you know..being judged." (Female, P3, Centre C) and because it documents and records what does happen in the course of assessment conversations and activities, is particularly valued when there are concerns about a trainee, as these assessors highlight:

"…if you were just to take a trainee on one side and say you know I really don't think you did that very well, or are you struggling, what's going on? They would say, well, that' s your word against mine..so when we have trainees that aren't doing well we do have to make a conscious effort as a department to try and get some of these forms done so that it's clear on paper…" (Female, P15, Centre C)

"I've had that not long ago with a foundation doctor and I was concerned about their knowledge, I had an inkling and then because I was able to do the assessments with them then it sort of, it's more black and white." (Female, P7, Centre C)

In this way the system is also valued for helping to identify problems and address them, as explained in these examples:

"…it's particularly useful when you've got a trainee in difficulty because it comes out I think more quickly that there are problems and it's a good way of, you know, recording evidence." (Female, P7, Centre C)

"We have had one trainee who was in really big difficulties so we did about 20 [assessments] on him and that actually was very helpful because..first of all we were demonstrating that he was getting better on the things that we were all worried about but equally we were able to identify the area that was problematic." (Male, P11, Centre C)

The concept of assessments as 'evidence' was seen to have two sides; on the one side seen in the quotes above it is valuable to record what is actually happening so that both parties can agree on this, moving beyond 'hearsay', and agree on future action, but on the other side there is a growing awareness that assessments may be viewed more formally as evidence, ie, in a legal sense, with some suggestion that this may inhibit how they are used:

"…I suppose when I trained you sort of almost expected a bit of adverse comments and abuse and what have you. Now if you say anything adverse it's sort of almost 'oh that's bullying you know. It's…people are actually really quite

worried about saying anything negative for fear of being accused..” (Male, P1, Centre B).

“…we’ve just been through an industrial tribunal…and you know all of those records were scrutinized in forensic detail and so people have become you know, very wary about committing anything…negative to paper and so you have this kind of reversion to the old sort of system where there was a corridor conversation and whispers…” (Male, P4, Centre A)

Viewing assessments as evidence clearly confuses their intended purpose within a learning rather than legal process, and as seen in the quotes above, can inhibit the honesty within WPBA, a consistent theme in this research.

2. What assessors find challenging and what detracts from the value of assessment

The first two sections relate to practical aspects of the process of assessment that can be challenging to assessors. The latter two sections are issues relating to the system as a whole that assessors raised as challenges or criticisms.

2.1 Giving feedback

It was reported in Part A of the study that trainees perceive that assessors find it difficult to give negative feedback and this is wholly endorsed by the data from Part B. There was a common view among the assessors in the study that having to give negative feedback was a challenging aspect of being an assessor. This task was described as ‘not pleasant’, ‘difficult’ and ‘uncomfortable’ which reflect the views of the sample group as a whole. Just one made the distinction between giving negative feedback and marking someone ‘badly’ asserting that the feedback is not difficult but giving the mark is (this is a theme addressed in section 2.2 below). The predicament felt by assessors is well explained by this individual:

“you want to have a relationship with your trainee, you want to..encourage them..to foster their training and from another point of view you need them to perform at some level and there’s a fear that by giving..negative feedback you

might adversely affect how..they'll work in the department and when you work in a small team you need everyone to be pulling their weight.." (Male, P10, Centre C)

And another assessor puts it forcefully:

"we frankly..we duck it. We don't want to be nasty and destroy them you know, but they do have to know…and if you say well actually you look as if you don't give a **** and you don't like it, they say 'yes that's right' then next week they do absolutely zippo." (Male, P6, Centre B)

These views again echo a theme found in Part A that the need to preserve working relationships is a barrier to honest feedback. As one of these same assessors (P10) points out, there is a need to strike a balance between the nurturing, supportive educator and upholding good, safe clinical practice, as this assessor agrees:

"..at the end of the day we are here to look after the patients and..that has to be your priority…" (Female, P7, Centre C)

Nevertheless, she agrees it is tough and although one or two assessors were 'not afraid' to be honest, a clear finding is that being honest in feedback is a struggle for many, perhaps not only to do with a fear of litigation seen above:

"the assessment process has gone too far the other way in terms of .. it's all very positive and cosy in that respect and you know, doctors generally want to know how to improve so I think that is something we do badly." (Male, P6, Centre B)

Factors which help in giving negative feedback were acknowledged to be feedback that is targeted to specific areas; having a written record of the problem; the trainee's receptiveness; having skills in conversation of this kind and handling it sensitively. A common view was that verbal feedback is essential in the process and in fact 'the best way' to give feedback, however difficult:

"What you hope is it's the conversation that they'll learn from.." (Female, P3, Centre C)

> "I think that very focused one-to-one feedback is invaluable and I think that's probably where the most value comes out of the whole thing from the trainees' point of view…" (Male, P4, Centre A)

There was also agreement that this should be followed up with written feedback that confirms what has already been discussed, making 'the free text' comments helpful as well as a clear action plan.

> "..it's very helpful to have the written because otherwise you know, they can sort of forget what you've told them and if you've got it down there, I feel that there's a little bit more, shall we say pressure to make sure they've attended to all…it's on the record therefore they need to brush up on this, improve on that next time.." (Female, P3, Centre C)

In general this reflects the wide support for the qualitative elements of assessment which assessors were asked about, which are seen to be important in balancing the scores and tick boxes and in helping WPBA be a formative and developmental tool. Just one stated that expanding these elements would not improve assessment and another that they should remain quick to fill in. Some felt the written fields should be mandatory and would like more opportunity to put a comment, and one that some assessments should have 'no scales on' to make it easier to identify areas to concentrate on, "without it being seen as a great negative." (Female, P7, Centre C). Two assessors referred to the value of the 'old-fashioned' 'unstructured' references in this context, which allow "more free thought and encourages more critical thought" (Male, P2, Centre C) as this assessor also agrees:

> "where you can actually say, you know, this trainee will come promptly when called, they do go the extra mile, they summarise beautifully in the notes. All that sort of thing, it's better than docs and boxes." (Female, P15, Centre C)

The freedom of this format would be welcomed by some however, it is recognised that it would not be realistic to produce more than one in a rotation so it could not fufil the purpose of the assessments. In a similar way the value of the supervisor's report

was highlighted although for GP trainees hospital assessors are not included in that. Moves to improve communication between hospital assessors and GP trainers could be useful in this respect.

A number of other comments were made about optimising feedback which suggests assessors find strategies to make this challenging task easier. These include: giving immediate feedback; asking the trainee to assess themselves; having more than one person involved; booking a time for feedback; being away from the ward and without interruptions, although this is not always possible; and time to reflect on the feedback "to appreciate it as a formative process" as one explained (Male, P6, Centre B).

2.2 Use of scales and forms

There was a strong theme in the data from these assessors that there is a tendency to award higher rather than lower marks in assessments, because it is 'easier' which ties in with the finding above that negative feedback is difficult to give. Giving the lower grades can be hard for even the most experienced assessor:

> "And also if you're doing it with the trainee then there's always a tendency to go up rather than down which is, you know, quite difficult..this is particularly true of the bad ones where you feel they really are not very good…you tend to sort of drift upwards." (Male, P6, Centre B)

There was some suggestion this may in part be due to the status of the trainees as professionals as well as their expectations which are difficult to dash:

> "This is the trouble, you're dealing with a group who have been high performers all their life and..you know, they are already qualified professionals and you're putting them in a place where you're sort of saying you know, this isn't quite good enough. That for some trainees, that can be quite crushing.." (Female, P3, Centre C)

The face-to-face aspect, as highlighted by the trainees in Part A, is part of the problem as this assessor explains:

> "It's quite hard when they come to you and they're sitting there and you're ticking their boxes, it's actually quite hard to put 'poor' sometimes.." (Female, P15, Centre C).

In addition to finding it difficult to give lower grades, there was some suggestion that this was partly explained by the scales or forms not being well understood which has training implications, touched on in section 4.2 below. The forms were also criticised for being 'very GP oriented' and not fitting into hospital posts, a finding which was highlighted in Part A of the study and has since been amended in WPBA. On the whole assessors did not highlight any consistent gaps in the assessments with just one having strong views that the forms did not capture 'professionalism' giving the examples of time keeping and attitude to work; the same assessor would like to capture feedback about 'history taking and documentation' highlighting poor grammar as part of this:

> "..perhaps I'm old fashioned but…there are things..I think they ought to be able to do like write a decent letter…" (Female, P3, Centre C)

As in Part A also, there are time issues in completing assessments that assessors highlight as adding to the burden. There is a feeling that proper time should be spent over the assessments, away from the ward, with some booking specific time for this although this is not always achievable; and also that not enough time has necessarily been spent with the trainee to get to know them properly, due to shorter rotations. This has the potential to reduce the value of the assessment as explained here:

> "In the end it always reflects how well you know the trainee and that's all about how much time you have been able to spend with them..the better you know them the better the comments will be, in a way..." (Male, P10, Centre C)

This pressure is felt despite the fact that consultants are allocated time for 'supporting professional activities' giving them 1.5 sessions per week "when I'm supposed to not have clinical duties" as one explained, though for some this does not seem realistic as this same consultant continued:

> "..but it's not filled up with GP trainee assessments, it's filled up with everything else." (Female, P14, Centre C)

2.3 WPBA is a 'blunt instrument'

Eleven assessors volunteered remarks that revealed the common perception that WPBA as a system for assessing trainees is a rather crude system which draws the line between pass and fail but does not go beyond a basic judgment of competency to discriminate between different levels or to nurture or recognise excellence. In essence the standard to pass has been set too low so that failing is unacceptable for all but the weakest trainees, which contributes to the inflation of scores and lack of honesty discussed above. In the words of two assessors it is a 'blunt instrument' for the task of assessing doctors' performance in practice. As this consultant explains:

> "..this is designed to push on the floor, it's to try and make sure you pick up people who are going to be a disaster in the future" (Male, P11, Centre C)

As he points out this means that those who fail are a much greater cause for concern which should alert trainers, although many referred to their confidence in identifying failing trainees anyway, but it also means the system is not designed to 'exercise excellent trainees' thereby denying any recognition of those who aim high.

> "I think we have some excellent trainees and part of the problem is finding a system that doesn't make them feel like they're kids, you know." (Female, P3, Centre C)

One assessor felt this lost an important point of the assessment exercise. Just one commented that setting 'fair minimum standards..probably fulfils a role' (Male, P8, Centre C) The lack of discriminatory value was mentioned by other assessors, as reflected here:

> "..you end up rating two trainees that are poles apart, absolutely the same." (Female, P3, Centre C)

And there is recognition that trainees can inadvertently bias themselves and lose out here:

> "..they don't necessarily reflect the skills of the trainee. I think the poor trainee can chose to use their good ones and a good trainee may actually put less good ones in their portfolio." (Male, P8, Centre C)

But there was some positive suggestion that the system at least creates a dialogue, as illustrated here:

> "No it doesn't benefit you by doing work based assessments, you don't identify anything you didn't know already. What it does it gives you a forum for telling someone that they are good but actually I don't think it's a good discriminator.." (Female, P13, Centre C)

This suggestion that the conversation around assessment is more valuable than the assessment itself is raised by another consultant here, but is also strongly emphasised in section 2.1 above about the importance of verbal feedback:

> "a trainee recently..he'd done a fantastic summary of the case, he had a whole plan there, and that sort of thing you think, well that's fantastic and I said to him when you come back at the end remind me to put that in the box..but you know, as far as he was concerned the fact that I said oh that's really brilliant..is I think what he wanted to hear. I don't think he cared about the piece of paper at the end." (Female, P15, Centre A).

2.4 Awareness of poor attitudes

Echoing these negative views of WPBA are comments that reveal that many recognise that the system is seen as 'cursory', 'a rubber stamp' and 'tick boxing' which is likely to further weaken the value of the assessments:

> "A lot of trainees are just looking to basically populate their e-portfolios and not necessarily really engaging with it…a tick box scenario at the end of an attachment" (Male, P10, Centre C)

> "Yes the whole thing is totally artificial and it's filling an e-portfolio for the sake of filling an e-portfolio…a lot of us feel that it is all just a paper filling exercise so neither the trainees nor us are particularly enthusiastic about it." (Female, P15, Centre C)

Alongside these comments which reflect a theme evident throughout other evaluations of workplace-based assessment within the Foundation programme and speciality training, it is also clear that some assessors see the importance of tackling such negative attitudes:

> "I think you know there is quite a significant selling job that needs to be done on the point of these things, to both trainers and the trainees…if we were all focusing on its core raison d'etre it would probably work more effectively." (Male, P11, Centre C)

> "..I think we just need to be more engaged as supervisors really don't you?" (Female, P14, Centre C)

One assessor who expressed particularly strongly that there were negative views among surgeons referred to the importance of making the assessments 'seem realistic and relevant to everyday practising surgeons' (Male, P4, Centre A)

3. What issues arise from working with GP trainees in particular

3.1 GP STs compared to other speciality trainees

Assessors were asked about their experiences of working with GP STs. Two assessors referred to individual differences in terms of maturity and clinical knowledge, which arise among all trainees, affecting what the individual brings to the post but there was no strong consensus about GP trainees compared to other speciality trainees. Two consultants referred to the fact that GP STs already know their career path, which can mean that they see the rotation as something to get through rather than something significant that they can get the most out of, and one other remarked that there was less interest in practical skills within the speciality

which was ‘a shame’. One other commented that the GP training as a whole focused too much on process rather than content such that:

> “…you get people who are very good at being very nice to people and communicating with people but not necessarily having the things that they need to communicate.” (Male, P11, Centre C).

But overall there were no strong views that GP STs were viewed differently. One distinct sub-theme arose in remarks about the typically high standards of the GP trainees encountered by the consultants in the study, with seven assessors volunteering such comment, which is likely to reflect positively on the GP training scheme as a whole.

There was some acknowledgement that GP trainees have different needs and at times different priorities, but this can be accommodated with the balance of patients they see and other adjustments to the rotation, as this assessor explains:

> “I think it’s up to the assessor and the trainee to focus on things which are likely to be relevant to general practice and maybe that’s where we could do with some guidance from..our GP colleagues in terms of what they’re looking for from their trainees and what [they want] them to get out of a..post.” (Male, P4, Centre A)

The reference here to knowledge about GP training requirements and standards is a theme addressed in 3.2 below.

3.2 Assessors knowledge of GP standards/requirements

Discussion around this theme provoked some interesting reflection on the knowledge-base on which judgements about GP trainees are made. Twelve consultants commented that they were not overtly familiar with the standards required for a qualified GP so that judgements made about a trainee’s needs and outcomes in the speciality become quite subjective, as this assessor makes clear:

> " I don't really, in an absolute sense, however as a specialist who gets lots of referrals from GPs I know what they tend to know and what they tend not to know.." (Male, P11, Centre C)

This implies that an assessor may reach their own judgements about what a trainee should know about a speciality by the end of the rotation rather than what is prescribed in the curriculum. Although this particular assessor felt strongly that he was the right person to be judging a trainee's core skills, it is worth noting he was highly experienced in his educational role. This assessor agrees with the subjective nature of judgements when she remarks:

> "I mean I guess we all do just kind of guess where we think and we get that..from previous trainees but we may..all have our own separate standards that we expect trainees to reach." (Female, P12, Centre C)

Other references were made to 'extrapolating' the standards and relying on personal experience 'about 10 years ago' and having a family member who is or was a GP. Although many feel they can judge what a trainee should know, the data here emphasise a gap in assessors' knowledge of the GP syllabus and requirements and highlights the possibility for error, particularly for those who admit, as one assessor did, not to "fully understand what a GP does". (Female, P7, Centre C). Clearly training in this area is implicated as discussed in 4.2 below.

4. Assessors views of training in assessment

4.1 Training undertaken

Assessors were asked about the training they had undergone in relation to assessment of trainees. The types of training completed included half-day locally based training (through the Deanery or Trust) although this was not always specific to WPBA but may have been about giving feedback, appraisal or supporting doctors in difficulty which are seen to demand many overlapping skills. As many assessors had a wider educational remit or role, four consultants also referred to undergoing training organised by Royal Colleges in relation to becoming an educational supervisor or college tutor and one had completed a Masters in Medical Education. Two referred explicitly to being training programme directors and two others referred

to roles on boards/committees relating to assessment either locally or at Royal Colleges, and two others had themselves delivered training relevant to assessment, which suggests this sample of consultants included some with extensive experience. Training was face-to-face in all cases and some referred to the use of videos and role-play activities. Overall, training was felt to be sufficient though remarks were made that it was quite superficial and for several was quite some time ago, and it was acknowleged by two that it is important in addition to attending training, to have time to reflect on it in order to consolidate learning.

4.2 Training updates – views and topics

The topic of training updates was discussed in all interviews and there were mostly neutral views about the idea of updates although three assessors explicitly stated they would not wish these to be mandatory given the pressure to attend so much mandatory training which as one remarked:

> " generates anti-bodies in a reliable fashion." (Male, P11, centre C)

This view was implied in the comments of other assessors that recognised the difficulty of getting people to attend; that not everyone might require this, such as those with wider educational roles; and that infrequent updates would be sufficient, perhaps every three years. One commented that just taking part in the interview for the study had itself been a useful opportunity to think about and give feedback on assessment. Overall the support for updates was lukewarm, however some useful suggestions for specific topics for training were raised, that might help initiate further interest among those reluctant to seek out training. These included: using the e-portfolio (mentioned by two); using the scoring system in assessments (three); recent changes to WPBA (such as adjustments to tools or forms) (four) with one remarking the constant changes cause frustration among assessors:

> "and it actually puts them off the role as well." (Male, P8, Centre C)

The two most significant topics were firstly, information about the GP syllabus and requirements/ standards for a qualified GP including current training goals (raised by

six assessors) where there seemed to be difficulties with finding information about the GP syllabus and understanding more about what is expected will:

> "..help us..to provide better training for our GPs if we know what standard they have to reach.." (Female, P13, Centre C)

Having a GP trainer providing this kind of input would also give the opportunity for assessors to ask questions 'that particularly suit them' as one explained.

Secondly, the issue of feedback skills was a common topic, tactfully described by one as:

> "mastering the art of politely letting somebody know that they could do a little better in this…" (Female, P14, centre C)

which again reveals something of the diplomacy involved for these assessors in giving feedback. This was mentioned by six assessors, with one feeling strongly that training for trainers was needed because:

> "it's quite obvious from talking to the trainees myself, they..say I haven't had an assessment like this where we've actually discussed things..There's clearly a need to train the trainers and to reinforce to them that actually you do need to be a bit judgemental..we need training to do that in a constructive way" (Male, P6, centre B).

One assessor, a TPD, emphasised the importance of simply:

> "getting people to understand you know, what we're trying to do with these assessment tools and how to use them…what's expected out of the process". (Male, P4, Centre A)

In terms of the format for update training, there was convincing support for training that brings people together, face-to-face to talk through scenarios and

discuss experiences and, despite some negative views about it, the use of role play which is seen to have benefits, as one assessor explained:

> "I think the reality of doing it is very different to working through it on the computer and on your own…I don't think there's any substitute for that kind of reality, actually doing it." (Male, P4, Centre A).

Although one assessor voiced support for training delivered via e-learning, there were some strong expressions against this, such as here:

> "Everything is going more and more e-learning, oh no, no please not that!" (Female, P3, Centre C)

5. How quality can be improved in assessment.

5.1 Ways to support assessors

Assessors would value greater contact with GP trainers or supervisors and although assessors could make contact with them not many talked of doing so. It would be beneficial to have GP input into training events (see 4.2 above) but also more regular communication about trainees would be helpful to share information, both about weaker trainees as in this example:

> "..when we did have a slightly difficult trainee, who was..just struggling a little bit we worked quite closely with the GP educational supervisor and that seemed to work well in that instance and I think that's where I'd be looking to strengthen the process.." (Male, P4, Centre A)

But also about good trainees, as in this quote, which may be one approach to helping WPBA identify excellence:

> "I had a particularly good one recently so I contacted her Educational Supervisor saying, look I haven't just ticked all the 6s for this girl, she really is fab and she's particularly good and I want you to know that and he emailed me straight back

and said ‘oh thanks ever so much that was great to know that, I’ll log it’..” (Female, P14, Centre C).

As one assessor highlighted, this kind of contact could also be used for giving the consultants feedback on the placements and training they are providing and another one suggested that the GP supervisor could give some background on a trainee’s strengths and weaknesses and things to work on during a rotation. Easy access to email contacts and reminders could help this become an informal yet regular part of WPBA reporting, giving assessors in hospitals greater support with their GP trainees.

Assessors find it helpful to discuss assessments with colleagues either those who are ‘very informed in terms of medical education’ or just departmental colleagues and this is an informal but valuable form of support. One assessor who did not seem to have a peer with whom to share the work raised the idea of an assessors ‘get together’ or forum for sharing skills and maybe even to get trainees to participate “you know, boot on the other foot” (Female, P3, Centre C). There was some support for this idea though concerns that it would need to be well chaired to avoid it becoming a ‘moaning shop’.

The idea of a lead assessor role was raised with participants but there was no convincing support for this. It was felt to be a difficult role to fill and may not have credibility across the specialities, and not be as useful as the support that could be offered by GP and other colleagues as discussed above.

5.2 Quality assurance

Consistent with the findings in section 3 above, there was conviction among the assessors of the need for greater clarity about the standards required of a GP trainee and ‘what kind of levels you’re aiming for’ and suggestions around this included greater communication between hospital specialists and GP trainers (as discussed in 5.1) as well as more basic initiatives such as two sheets on:

“what a GP should be picking up in the..hospital post” (Female, P12, Centre C)

"a guide list of..the top ten things that the GP trainers feel they should be learning when they're with us" (Female, P15, Centre C)

"a list of requirements that we as assessors are expected to fulfil" (Male, P4, Centre A).

There were also suggestions such as those seen in 4.2 above relating to training, in areas such as consistency in how the scales are used, giving feedback as well as in standard setting. Two assessors raised the idea of an audit of assessments, 'a hawks and doves analysis' as one put it, to identify those who are marking everyone the same or other problems, as this would build in a measure of feedback into the system. The idea of being observed by a peer to give the assessor feedback on their assessment skills was raised by one person, and then this idea was discussed with other assessors. Most deemed this a good idea in principle although it was felt to be hard to implement routinely. It may be an element that could be incorporated into a training event rather than into routine practice.

Just one assessor had strong views against making any changes to the system believing it should be left to run for 5 years to give those involved a chance to adjust to it.

Discussion

Workplace-based assessment is now in its fourth year within GP training and these data capture a snapshot of how it is working for assessors in hospitals and deepen the insight achieved from Part A into the roll-out of a complex system in a busy clinical environment. It is encouraging that the picture conveys some positive elements within WPBA but there are a number of challenges revealed in the data that should be heeded if quality in assessments is to be upheld and outcomes maximised.

Assessors value the mandate created by the system to give feedback that trainees need and having this process ensures that feedback does indeed happen. GP trainees do not present difficulties for assessors responsible for their hospital-based experience, indeed the high quality of GP trainees was noted by many. However, assessors are not familiar with the standards required within GP training and there is subjectivity around such judgements which could be avoided with better understanding of the curriculum and standards. Assessors could be supported in obtaining this knowledge through training but would also benefit from better links with GP leads and supervisors more generally, which may help with other areas such as communication about trainees, both weaker ones where extra support is needed and stronger ones who should be recognised. Such links could be an informal yet regular part of WPBA reporting.

There is value in the concept of assessments as evidence, in generating a record of the discussions that take place and agreement between assessors and trainees about what needs to happen, but there is rightly caution about how such evidence may be used. This brings one of the challenges seen among these assessors, that the concept of evidence may inhibit honesty, a strong theme in Part A of the research and further endorsed here, where assessors are also constrained by the need to preserve a working relationship with the trainee such that lower grades and the more difficult negative feedback may be avoided. Assessors must negotiate the fine balance between nurturing the trainee’s development and upholding safe clinical practice and this makes it crucial for assessors to understand constructive feedback and have the skills to give it. In this study, despite the mandate many say they

struggle with feedback consistent with an earlier study[1] which highlights another area for training.

Verbal feedback in particular is recognised to be a valuable part of the assessment process, as seen among the trainees, and there is conviction that the qualitative elements in WPBA bring an important depth to the process that might otherwise be just 'docs and boxes' and allow a more personal dialogue to take place that ensures a focus on formative not just summative learning. However, time to deliver feedback properly, and time for the trainee to reflect, as well as individual skills in this area remain barriers to high quality feedback and there is a clear call for further training and support among peers to capitalise on this aspect of WPBA. The significance of this element of assessment is emphasised by Archer who advocates the nurturing of a new feedback culture which breaks down the 'hierarchical, 'diagnostic' lens' approach in current models within medical training, to bring a more integrated approach in which feedback is 'conceptualised as a supported sequential process rather than a series of unrelated events'.[8]

Alongside the issues of individual skills, organisational and indeed cultural factors which could be strengthened to maximise the formative learning from assessments, there is a serious challenge faced by assessors which may threaten this goal. This relates to the perceived failings of the system as a whole to motivate doctors to learn rather than pass assessments. Assessors refer to WPBA as a 'blunt instrument' that is focused on a minimum standard of competence and the lack of discrimination between trainees of different calibre is seen to de-value excellence which loses an important motivation among trainees. This weakens the underlying assumption in WPBA that the system should, through regular assessments and highlighting areas for development, help deliver better doctors. It may also partly explain the poor attitudes seen in this and other studies[1,4,11] among both trainees and assessors who talk of cursory judgements and ticking boxes. With further recent evidence of this kind from the report by Collins relating to similar assessments within Foundation training,[12] this represents a significant threat to the underpinning principle of assessment, that should no longer be ignored if the perceived validity of WPBA as well as the outcomes from it are to be improved.

Recommendations

The findings of the project suggest a number of areas in which changes could improve the assessment process within hospital placements:

- A key strength in the system is perceived to be in the professional conversation, the free-text comments and the action plan; the process could be modified to facilitate and encourage this and this emphasis similarly reflected in training.

- In the Severn Deanery's School of Primary Care GP Educational Supervisors (ES) and GP Clinical Supervisors (CS) are required to go on a refresher course every three years prior to their re-approval as supervisors. It may be appropriate that this should occur for hospital based supervisors.

- On the GP ES courses the participants are obliged to do CbD and COT assessments with their peers who are on the course as well as with GPSTs who are invited to come to help on the course. These assessments are observed by their peers who give the ESs feedback on their performance using the Cambridge Calgary[13] methodology. It may be appropriate for this occur in a similar way for hospital based supervisors. As has been suggested in the research interviews it would also be useful if some GP ESs could be involved in the training sessions.

- A particular focus in the training should be on how to give constructive feedback and how to handle giving low grades. This research shows that hospital supervisors find it very difficult to give what is perceived as negative verbal and written feedback. Experiential training in giving this negative feedback, which is in fact formative and developmental, could enhance the initial training course and refresher courses for hospital supervisors.

- It would be very helpful if the hospital supervisors doing the WPBAs for GPSTs had access to the competences in terms of knowledge and skills for their speciality from the GP curriculum guide. A summary of the GP curriculum relevant to each speciality could be attached to the e-portfolio.This should be

used at the start of the post when the initial Learning Needs Assessment is performed.

- Increased regular communication between hospital supervisors and the GPST's GP ES would be of benefit to both parties as well as to the GPST. To facilitate this, names and contact details (best phone number, email address) of CS and ES could be available on the STs' e-portfolio; possibly with automated reminders to the Trainers to make contact.

- Improving the informal contact between hospital assessors and GP trainers could offer a way to share and capture information about better trainees, helping to nurture a culture in which excellence is also recognised.The RCGP may wish to consider ways to capture such data formally within the portfolio to help motivate trainees as in the previous system where merit and distinction grades were possible.

- Self-assessment by the GP ST is at present only part of the ESR. Greater use could be made of self assessment as has been used successfully in GP training using tools like the Manchester Rating Scale where the GPST's self assessment is compared with the GPES's assessment and a final assessment decided upon. There could be a downloadable self-assessment form for the ST to use before they are assessed by their supervisors.

- The idea that it should be possible for assessors to compare their mean scores with national averages for CSs would help self-calibration.

- The RCGP may need to review and address the concern that assessments could be used as (legal) evidence which inhibits what they put down on record.

Conclusions

This study has successfully captured the views of senior medical colleagues assessing GP STs while in their hospital posts. A valuable positive outcome is that GP STs are valued in hospital posts and of usually high calibre. The work has

consolidated certain of the themes identified in the earlier phase involving trainees, emphasising those where action should be taken to preserve the underpinning principle that assessment should help deliver better doctors. In particular, giving negative feedback is difficult and assessors admit leniency. This is largely about preserving a good working relationship but the fact that trainees recognise the leniency and the limited feedback received, threatens to undermine the educational experiences of trainees. The professional conversation and scope for free text comments are important to both parties and hold the most potential for bringing value to the process. A major concern is the absence of any recognition or credit for going beyond the basic competencies which loses a hugely important motivation among trainees to learn. The project has captured something of the culture change taking place within postgraduate medical education in which these assessments are now more or less accepted, but it remains important that all those involved are committed to WPBA and its principles. A number of recommendations are offered, emerging from the findings, to help build this commitment and maximise the educational outputs from the system.

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Appendices

Appendix A: Participant Information Sheet

University of the West of England
BRISTOL

Information Sheet for Interviewees

Project: What are assessors' views of completing Workplace-based Assessments with GP trainees?

You are being invited to take part in the above research study. Before you decide whether to proceed with taking part in this next stage, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

The purpose of the study:

The purpose of the study is to explore the views of hospital-based assessors undertaking Workplace-Based Assessments (WPBA) with GP trainees. The aim is to find out what assessors find useful and challenging about assessing GP trainees; the best way for assessors to learn about assessment and support high quality WPBAs; and to explore the feasibility of the role of a lead assessor to support WPBA in hospital posts. The study has been approved by UWE Faculty Research Ethics Sub-Committee at their meeting on 25th May 2010.

Why you have been chosen:

You have been chosen to take part in this research because you are involved in the assessment of GP specialist trainees at one of three locations within Severn Deanery chosen for this study.

If you do not wish to take part:

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if you decide to take part:

You will be sent a reminder of the date, time and location for the interview as agreed with you. The interviewer will be the project manager or an experienced GP researcher working on the project.

The interview is expected to last up to 40 minutes and will be guided by the aims given above. Your permission will be sought to digitally record the interview but the discussion, digital record and any other notes will be kept entirely confidential (see also the later section on confidentiality). The information arising from the interview will be analysed with data from other interviews or focus groups in the study and the collated findings will form the basis of conclusions and recommendations from the research. The research study as a whole is planned to take place across eight months

The possible disadvantages and risks of taking part:

No adverse effects, risks or hazards are anticipated from taking part in the interview.

The possible benefits of taking part:

There are no direct benefits to study participants. Information gained from the study may help others in the future.

If something goes wrong (handling complaints):

In the event of a complaint arising in connection with the research, participants may contact the steering group for the project, headed by Dr Pat Young, Senior Lecturer, UWE, Faculty of Health and Life Sciences, School of Health and Social Care, Glenside Campus, Blackberry Hill, Bristol BS16 1DD.

Commitment regarding confidentiality:

All information which is collected from you during the course of the research will be kept strictly confidential. All data from interviews will be anonymised and your name will not appear on any documentation or recording. Only the researcher present at the interview will have access to names of participants. Transcripts, digital recordings and notes will be stored in password-protected computers and/or in a locked cabinet at the researchers' workplace, in accordance with the Data Protection Act (1998).

What will happen to the results of the research?

A report of the research will be made available within Severn Deanery, and a presentation will be given to which all hospital-based assessors within the Deanery will be invited. Publication of the research in peer-reviewed journals is also planned.

Who is organising and funding the research?

The University of the West of England, Bristol is sponsoring this research, which is funded by Severn Deanery.

Contact for further information:

If you have any further questions about the study please feel free to contact the lead researcher and project manager: Abigail Sabey, Senior Lecturer, University of the West of England, Bristol, Hartpury Campus, Gloucester GL19 3BE. Tel. 01452 702166. Email: abby.sabey@uwe.ac.uk.

Thank you for reading this and for taking part if you agree to do so.

You may keep this information sheet together with one copy of the signed consent form.

Abigail Sabey, 30th April 2010
Version 1

Appendix B: Topic Guide for Interviews

General views on positives and negatives of WPBAs and being an assessor

1. What do you value about workplace-based assessments?…and what do you not value?

2. What do you feel you do well and less well as an assessor? (*Probe*:ask about practical/administration, giving feedback, giving action points/development plan)

   Probe for views on giving feedback – How do you find giving feedback to a trainee? (then if relevant) Can you identify what in particular, makes it difficult to give negative feedback to trainees? How do you find verbal or written feedback in this regard?

Working with GP trainees in particular

3. What are the most challenging parts of being an assessor of GP trainees?

4. How knowledgeable do you feel when working with GP trainees about the standards required for a qualified GP?

5. (If not already raised) How important is time for the role of assessor? How important is recognition for the role?

Training

6. Have you undergone any training for the role? Was this at the Trust/Deanery? What was the format and length. How helpful was this training? Was it sufficient?

7. How helpful would update training be and how often? Are there particular things it would be helpful to update on?

8. What do you think would be the best way for assessors to learn about how to do good quality WPBAs? (*Probe*: face-to-face, e-learning, any other ways)

Support for assessment

9. How could you be better supported with assessment of trainees?

10. What do you think about the idea of having a 'lead assessor' in the Trust, someone with responsibility for overseeing the process and ensuring quality? What responsibilities might this include?

11. How feasible do you feel this role is in terms of: suitable/willing candidates, releasing someone from clinical duties, funding, acceptability of cross-speciality assessment (ie, consultants assessing in other wards/specialties)

12. Is there anything you could suggest that would improve quality in assessment? (explain background to this from first phase.

13. Is there anything else you would like to raise in relation to this topic?