Workplace-Based Assessment for GP Specialist Trainees in Hospitals:

How is it actually working?

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Introduction and background

Changes in GP education and training

In 2006 the Royal College of General Practitioners (RCGP) introduced a new, competency-based training curriculum for general practice, spanning three years of GP education and training in hospital and general practice posts.[1] This occurred within the context of a long-term programme of reform currently underway in postgraduate medical education in the UK, prompted by a series of significant societal, medical, workforce and health service developments in recent years.[2,3] These reforms, which follow those in undergraduate and foundation training launched by the Modernising Medical Careers initiative,[4] are bringing important changes to all branches of specialty training.[2]

The updating of the GP curriculum brings a focus 'more strongly than in the past on the knowledge, skills and competences that are required in general practice'[5] and has been followed by a new three-part assessment process introduced in 2007. This culminates in a new final membership examination for the College (nMRCGP). The three elements of assessment are mapped to the approved new curriculum, in keeping with Postgraduate Medical Education and Training Board (PMETB) requirements,[6] and include: an Applied Knowledge Test to assess the knowledge base required for independent general practice, taken at any time during the three-year training period; a Clinical Skills Assessment to assess a trainee's ability to integrate and apply the information and skills necessary for everyday situations in general practice; and thirdly, a system of Workplace-Based Assessment (WPBA).

Workplace-based assessment (WPBA)

WPBA is a system of performance assessment for doctors in 'areas of professional practice best tested in the workplace'[5] and is argued to distinguish between the 'can do' (competence) and the 'does do' (performance) of medical professionals.[6] PMETB have stated that 'workplace-

based assessment is set to become an extremely important component of specialist medical training'[7] and its prominence in GP training further confirms the value placed on this type of assessment in postgraduate training first seen under Modernising Medical Careers.[4]

As in workplace assessment during foundation training, GP specialist trainees are required to collate evidence of competence in core areas of the GP curriculum via assessments undertaken in day-to-day practice during hospital and GP placements which 'allows assessment of what the trainee actually does in clinical practice rather than simply what he or she can do' as well as providing a way to assess certain competencies that 'are difficult to assess elsewhere, for example, team working'.[8] Standardised tools are used to capture evidence, which are widely used in other contexts of doctors training including the foundation programme in the NHS[9] and internationally.[10,11,12,13] These include: Case-based Discussion (CbD), Mini-Clinical Evaluation Exercise (mini-CEX) (and other consultation observation tools for use in general practice settings), Multi-source Feedback (MSF), and Direct Observation of Procedural Skills (DOPS). Specified numbers of each assessment are completed during each placement (see below) with a Consultant Supervisor's Report obtained at the end of each one. An important feature of these assessments is that there is no pass/fail standard with the tools serving to provide material for feedback to the trainee and their supervisor regarding progress and learning needs and in this sense they are formative assessments. It is not until the end of training that trainees must demonstrate competence for independent practice (and licensing), which is a key difference to assessment during foundation training.

In addition to formal assessments, GP trainees 'are equally encouraged to collate naturally occurring evidence that can be used to demonstrate their journey to competence'[14] which can be recorded in their electronic portfolio alongside WPBA assessments and other learning activities during training. In addition to a GP educational supervisor to monitor and support progress across the three-years, a clinical supervisor is appointed during each post to

oversee the work and training of the GP trainee including on-the-job teaching and support with and/or input to, assessments.

WPBA assessment tools

Case-based Discussion

For this assessment, the trainee selects two cases (or four in ST3) in which they have been involved and provides the notes one week in advance to the supervisor who selects one case for discussion. The discussion is designed to explore professional judgement and competence in some of the areas defined in WPBA and to last about 30 minutes including giving feedback and completing forms. It is intended that a balance of cases is selected, from a range of patients and settings (e.g. children, mental health, cancer/palliative care and older adults[15]). A minimum of six CbDs must be completed in ST1 and 2, and twelve in ST3, with evidence feeding into the six-monthly and final reviews.

Case-based discussion is an element of many peer assessment programmes world-wide, and has its origins in the U.S. where it is known as chart stimulated recall. It has been used as part of the General Medical Council's performance procedures[16] which informed the development of the CbD tool for the NHS Foundation Programme.[9] It provides a structure for the discussion of four key areas: problem definition, clinical reasoning, management and monitoring health (anticipatory care). The tool is designed for both hospital and GP settings[15] and is also being used in other specialty training programmes such as medicine and paediatrics.[17]

Mini-Clinical Evaluation Exercise

The mini-CEX is described as a '15 minute snapshot of a single doctor/patient interaction within a secondary care setting'[5] and assesses clinical skills, attitudes and behaviours in relation to high quality care. The interaction may be assessed by staff grades, experienced specialty registrars or consultants but a different assessor must be used each time. Feedback is given

immediately after the interaction and as with all assessments, is recorded in the e-portfolio. Six mini-CEXs are undertaken in ST1 and ST2 in hospital posts (or using a slightly different tool in primary care posts – the Consultant Observation Tool (COT)) and a further twelve using COT in ST3.

The mini-CEX was also first developed in the U.S. and has been shown to have high reliability[18] and validity[19] and the potential 'to provide high quality, interactive feedback that could contribute to improvement in trainees' clinical skills'.[20] It is widely used in the U.S. in the assessment of both qualified doctors and medical students. Minor changes were made to the mini-CEX for use within the NHS Foundation Programme where evaluation is ongoing.[21]

Directly Observed Procedural Skills

The DOPS tool assesses the trainee's skills on certain mandatory procedures with assessment intended to take 10-20 minutes including five minutes for feedback and as with mini-CEX requires a different assessor for each encounter. As Wilkinson et al (2008)[22] explain DOPS is similar to the mini-CEX with the exception that the whole procedure is observed not just part of it. One assessment for each of eight procedures must be completed by the end of training.

Direct observation of trainees' clinical skills is now regarded as a high priority in the U.S.[23] and in the UK the Royal College of Physicians developed the first DOPS tool in 2003 to improve the reliability and validity of such observation.[24] It is thus a more robust method of assessment than the traditional methods of log-books and informal opinion[24] and can be easily incorporated into everyday practice situations.

Multi-source Feedback

This tool is a questionnaire completed online by clinical colleagues working with the trainee, who give feedback on their clinical performance and professional behaviour. Five clinicians with different jobs (in secondary care) or five GPs plus five non-clinicians (in primary care) are selected by the

trainee who have all observed the trainee in the workplace, and invited to give feedback in a given timeframe. The educational supervisor/trainer should confirm with a sample of colleagues that they have contributed to the MSF with the trainee making efforts to receive a good response. Feedback is given during an interview with results made anonymous and set within the context of the trainee's overall performance to date. Two cycles of MSF are completed in ST1 and two in ST3.

Peer ratings have been identified by the Postgraduate Medical Education and Training Board and the General Medical Council as suitable for postgraduate assessment and revalidation, building on a body of work from the U.S. and Canada which established this as a feasible method capable of generating valid and reliable assessments.[25,26] A multi-centre evaluation of various WPBA assessment methods for use in GP training[27] demonstrated high reliability for MSF and concluded that this assessment was suitable for 'a high stakes judgement on the outcome of training' making it a robust element of WPBA in general practice.

Consultant Supervisor's Report

This also forms part of the evidence gathered for WPBA and is completed by the clinical supervisor at the end of each hospital post referring to the trainee's knowledge base in the relevant clinical area, practical skills and professional competencies. The report should identify any developmental needs arising from the post and areas of strength shown by the trainee, and feeds into the six monthly and final reviews.

How are the workplace assessments working?

As cited above the reliability and validity of the tools in certain contexts have been evaluated and they are considered fit for the purpose of WPBA[6] with some evidence supporting their use in other specialty training.[22] However, what is less well established is how the tools function in day-to-day practice within GP training or how valid and useful they are found to be by trainees,

and thus the success of WPBA in judging progress through training and generating 'feedback for learning'[28] is so far unknown.

Aims of the study

Given the scale of the changes in GP training and assessment it is likely that early lessons can be learned from the initial implementation of WPBA, to the advantage of future cohorts of trainees and this makes an evaluation of WPBA timely. Within Severn Deanery which delivers WPBA to trainees across a geographical area reaching from North Somerset to Wiltshire and Gloucestershire, it emerged during the first year of the assessments that little was known about how the new assessments were actually working for trainees, especially those based within hospital posts. There were concerns locally about trainees' knowledge of the process as well as practical issues relating to implementation of the new system which gave impetus for a local, in-depth evaluation of WPBA to highlight problem areas, suggest ways to improve the system in future and potentially contribute knowledge to this new field.

The present study therefore aimed to establish the experience of GP trainees undertaking WPBA during hospital posts, with the following specific questions:

- What do GP trainees understand about the WPBA process?
- What is the GP trainees' experience of using the assessment tools and completing assessments?
- What do the GP trainees feel assessors understand about the process?
- What are the trainees' concerns about WPBA?
- How do trainees suggest the process of assessment be made more robust?
- What does documentary evidence reveal about the use of WPBA?

Funding/Advisory board

Ethics approval

The study was approved by the UWE Faculty Ethics Sub-Committee in October 2008. NHS ethics approval was not required on the grounds that the study was an educational evaluation.

Methods

A mixed methods approach was adopted using quantitative and qualitative methods undertaken in two phases. The design was informed by a participatory approach typical of action research. In this, the active participation of potential research subjects in the research process is encouraged, to maximise the co-operation and support of those whose views are being sought and produce understanding that is useful to them.[29]

Sampling

Two of the five centres falling within the Deanery were selected to take part in the study. To give an opportunity to compare different areas within the Deanery, one training location with several large and medium sized hospitals accommodating GP trainees, was selected for comparison with one smaller location having one main teaching hospital. Initial difficulties in recruiting the smaller centre due to pressures on the GP timetable led to a change of location to one with similar characteristics. From these two locations, the total population of GP trainees currently in hospital posts (78 trainees) were targeted in phase 1 of the study.

Phase 1

The initial task of phase 1 was the design of a questionnaire. The purpose of the questionnaire at the outset was to gain information from the trainees about undertaking assessments and the assessment system as a whole with items relating to use of the e-portfolio, ease of finding assessors, time given by assessors, the tools, feedback and training. Following contact with the relevant GP educators in one of the two locations, an initial meeting took place with trainees to promote the aims of the project and generate discussion of WPBA to inform the selection of topics for the questionnaire. This confirmed that issues revealed in anecdotal evidence within the Deanery were highly pertinent to trainees, as well as themes arising in previous research relating to assessment within the Foundation Programme.[30,31] Items for the

questionnaire were drawn up by the lead researcher in consultation with the project team including the Deanery lead and was finalised in December 2008. A copy can be seen in Appendix A. A participant information sheet was distributed by email to all trainees via postgraduate staff (see Appendix B).

Distribution of the questionnaire commenced in January 2009. To encourage a high response rate, distribution was in person via attendances by the lead researcher (or academic colleague) at regular GP education sessions, for which permission was obtained from lead GP educators in the two locations and the Associate Dean of the Severn School of Primary Care, a collaborator on the project. Consent was deemed implicit in completion of the questionnaire. Several sessions were attended in each location between January and March 2009 and those trainees not in attendance were sent an electronic version of the questionnaire to ensure that all trainees had the opportunity to respond. Further responses were prompted by GP educators and/or email sent via postgraduate centre staff. Response rate from trainees in location B was much lower than in location A and further to the additional correspondence mentioned above, a letter was sent to all trainees in location B from the GP 'education scholar' to help boost the numbers and improve the quality of the data. Recruiting trainees to help promote the project to their peers was also attempted. However, by mid-March no more questionnaires were forthcoming and as an acceptable response rate had been achieved this phase of data collection ceased to keep on track with the project. A total of 52 responses were received giving a response rate of 67%.

Phase 2

Following analysis of the questionnaire data in March 2009, the qualitative phase of data collection began. This phase was intended to capture the views of trainees about particular problem areas identified through the questionnaire data, and to seek suggestions for improvements to the assessment system. The focus group method was chosen to achieve this. This research method seeks a broad range of ideas on a set of topics around one main focus, and involves bringing together small groups (typically 6-10) of relevant people who

interact with each other and the group facilitator.[32] Apart from the advantages of economy of time and effort afforded by this method, the group processes can help generate discussion and help individuals explore ideas and express views that may be difficult or threatening to disclose in a one-to-one format,[33] including negative views or dissatisfaction.[29] The natural questioning and challenging that arises in a group conversation is also considered to achieve more realistic data.[33] The topics for the focus groups were informed by the findings of phase 1 (see page 19).

All trainees in the two locations were given the opportunity to express their interest in taking part in a focus group at the time the questionnaire was distributed, with a view to selecting the first 8 at each meeting who replied, to convene up to 6 focus groups across the two locations. Overall, 31 expressions of interest were received from across the two locations making further selection unnecessary. All of these were followed up by the lead researcher via email giving further information about taking part (Participant Information Sheet – Appendix C) including two available dates in each location. In location A, six responses were received, three accepting and three declining due to other commitments. In location B, one positive response was received, two were tentative depending on rotas and one person declined due to work commitments. All positive responses were acknowledged and confirmed and those who were tentative were followed up nearer the date of the focus group to ascertain availability. In location B, the trainee giving a positive response was approached to help recruit peers to make a suitable focus group but this was unsuccessful.

Consent was obtained from all focus group participants prior to the start of the discussion. The first group convened in location A had four participants, with the fourth person being in addition to the acceptances received in advance. One trainee attending at a later date agreed to a semi-structured interview for the study, completed by the lead researcher. In location B, a semi-structured interview was undertaken with the one trainee who had accepted and confirmed attendance. Following this interview, the participant came forward to offer further help with recruiting his peers for a focus group which, although

he had tried at the time of initial recruitment and been unsuccessful, was then confident of being able to do so. This resulted in two focus groups in location B: one comprising 9 trainees and one of 7. Overall, 22 participants were involved in phase 2.

The discussions in groups or interview lasted between 45-75 minutes and were facilitated by the lead researcher. All discussions were recorded using a digital recorder and were transcribed verbatim by experienced transcribers from the research admin team. All transcripts were anonymised and data stored securely.

Analysis and results

Phase 1: Analysis

Quantitative data

The data from questionnaires were entered into SPSS version 15 by the lead researcher, and manually checked for missing data, double entries and anomalies. Simple frequencies were generated as part of this process, and data were prepared for the next stage of analysis. This included some recoding of data to obtain meaningful categories for comparison, e.g. data on years since qualification at medical school were grouped into less than and more than 4 years. The data were then scrutinised to highlight variables for further analysis using cross tabulations and correlation. The analysis process and output files were reviewed by a research colleague for integrity and completeness.

Phase 1: Results

Who was in the sample?

Of the 52 trainees in the sample, 26 were from location A and 26 from location B. Of these 38 (73%) were female and 14 (27%) were male, reflecting a fairly typical gender balance in GP training at the current time. A comparable gender split was seen in each of the two centres with location A having 77% females and location B having 69%. The age range was from 25-44 with 50 trainees in the 25-34 age group, and 2 in the 35-44 age group. 23 (44%) trainees were currently in ST1 and 29 (56%) in ST2 again with an almost identical split in the two locations. The majority of trainees had participated in a Foundation Programme prior to specialty training, with 10 not having done so. The average number of years since qualification from medical school was 4, with 77% of the sample being within 4 years of qualifying, with a range from 3-10 years.

These variables, which define the sample (location of Vocational Training Scheme (VTS), gender, current year of training (ST1 or ST2), whether the trainee had been part of a Foundation Programme, and number of years since qualification), were factors which may potentially affect views and experience of WPBA and were considered in further analysis of the data. Where associations were found these are reported in the text.

1. How useful do trainees find the WPBA assessment tools?

Trainees were asked about the usefulness of each of the four assessment tools, plus the consultant supervisor's report (CSR) completed at the end of each placement. The data are presented in Table 1 and illustrated in Figure 1 below.

Table 1. Trainees' ratings of the usefulness of each assessment (frequency and %)

Tool	Not very useful/useless (%)	Neutral (%)	Useful/very useful (%)	*Total*	Missing
MSF	2 (4)	11 (22)	38 (74)	51	1
CSR	2 (4)	18 (35)	32 (61)	52	0
Mini-CEX	29 (57)	17 (33)	5 (10)	51	1
DOPS	30 (59)	14 (27)	7 (14)	51	1
CbD	21 (40)	13 (25)	18 (35)	52	0

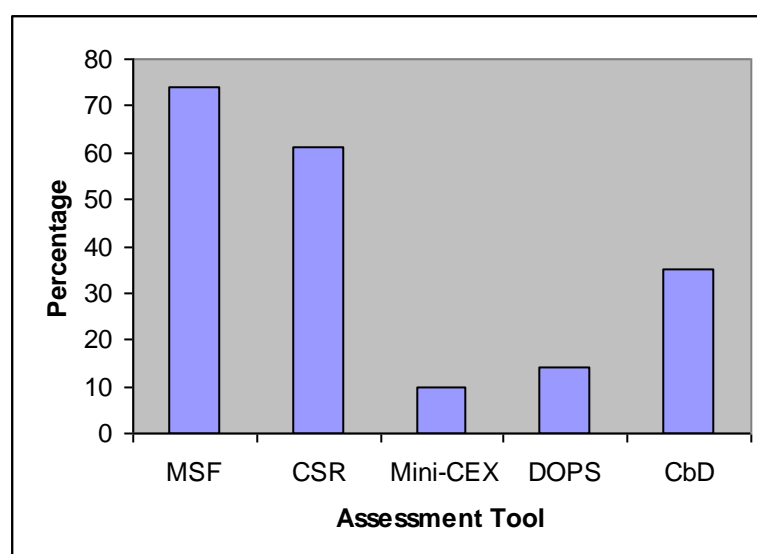*Figure 1. Percentage of trainees who rated each tool as 'useful' or 'very useful'*

Table 1 and Figure 1 show that the majority of trainees find the MSF and CSR useful (74% and 61% respectively) with no significant differences across the two centres or other variables such as year of training. However, the mini-CEX and DOPS assessments are not considered useful by more than half the trainees (57% and 59% respectively) though many trainees were neutral about these tools. Views about the CbD assessment were more mixed, again with many neutral opinions expressed, perhaps suggesting this assessment depends more on individual preference. Further analysis revealed that more

trainees in location A found the CbD assessment useful which was statistically significant when tested using chi-square (p=0.001).

Table 2. Trainees' views of CbD, across the two training locations

Location of VTS	Views of the usefulness of CbD, across the two locations (% within location)			
	Not very useful/useless	Neutral	Useful/very useful	Total
Location A	4 (15)	10 (39)	12 (46)	26
Location B	17 (65)	3 (12)	6 (23)	26
Total	21	13	18	52

Chi-square=13.817 (p=0.001)

Very few trainees select cases for CbD that have 'not gone well' (just 2%) though 55% report that in day-to-day practice they learn from such cases. This suggests that CbD is not being used as a learning tool and is open to manipulation. This theme was taken up in the focus group discussions.

Trainees are not convinced that any of the tools used in WPBA assesses additional competencies to those assessed in the Foundation Programme. The proportion responding 'yes' to this question did not exceed 35% for all tools.

2. How do trainees rate their experience of using the e-portfolio?

Trainees were asked to rate their experience of using the e-portfolio in terms of general features of reliability of access, navigation of the site, clarity of instructions provided and performance. Table 3 shows that trainees are broadly satisfied with e-portfolio access and use with the majority rating the four aspects seen in Table 3 as good or excellent.

Table 3. How trainees rate their experience of using the e-portfolio (frequency and %)

	Excellent (%)	Good (%)	Average (%)	Poor (%)	*Total*
Reliability of access	6 (12)	32 (61)	13 (25)	1 (2)	52
Navigation	29 (56)	19 (36)	4 (8)	0	52
Clarity of instructions	30 (58)	17 (33)	5 (9)	0	52
Performance	3 (6)	24 (46)	21 (40)	4 (8)	52

Figure 2. How trainees rate their experience of using the e-portfolio (as %)
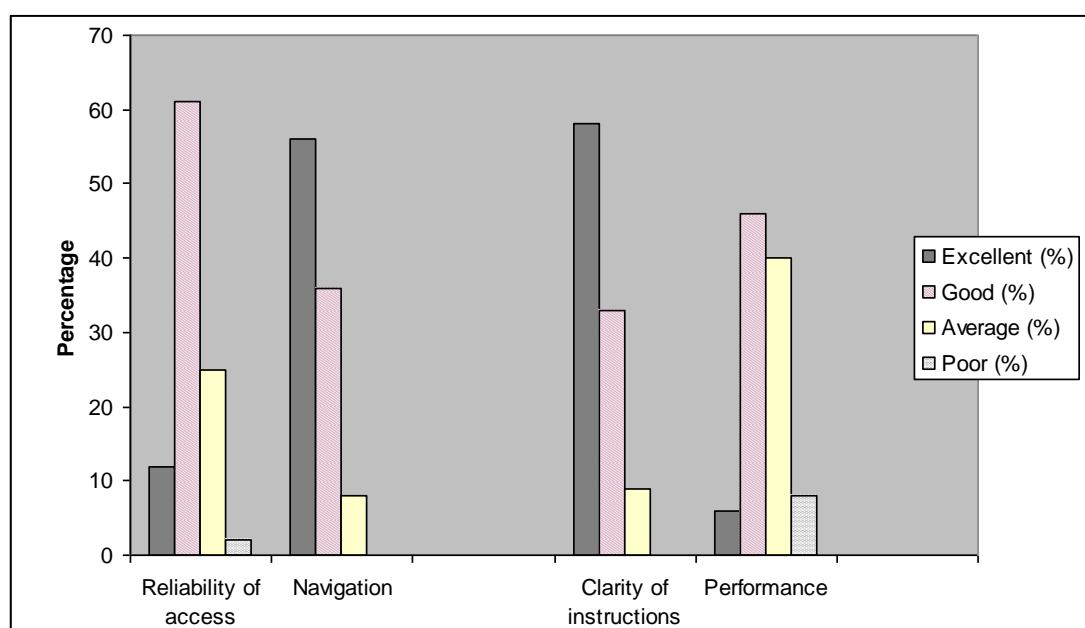
3. What aspects of WPBA are useful?

Trainees were asked a number of questions about the usefulness of different elements of assessment and the data are shown in Table 4 and Figure 3 below.

Table 4. Trainees' ratings of the usefulness of different elements of WPBA (frequency and %)

	Not very useful/useless (%)	Useful/very useful (%)	Total	Missing
Opportunity for face-to-face discussion	7 (13)	45 (87)	52	0
Being given a summary score/rating	34 (68)	16 (32)	50	2
Being given verbal comments/feedback	3 (6)	49 (94)	52	0
Being given written comments/feedback	13 (26)	37 (74)	50	2
Having an electronic record of assessments	14 (27)	38 (73)	52	0
Managing RCGP documentation	14 (27)	38 (73)	52	0

The one-to-one contact created by assessment is clearly a key element with the large majority (87%) of trainees rating the opportunity for face-to-face discussion as very useful or useful and almost all (94%) rating verbal comments/feedback as useful or very useful. Being given written comments/feedback is also rated as useful or very useful by 74% and on further analysis it was found that significantly more trainees in location A than in location B, rated being given written comments as useful or very useful (p=0.02) (see Table 5). The summary score/rating is not judged to be useful by most (32%) but again, more trainees in location A find this useful than in location B, though this association did not quite reach significance (p=0.06). Most trainees (73%) find it useful having an electronic record of assessments and that this is helpful in managing documentation required by the RCGP (also 73%). No other associations were found with location of training.

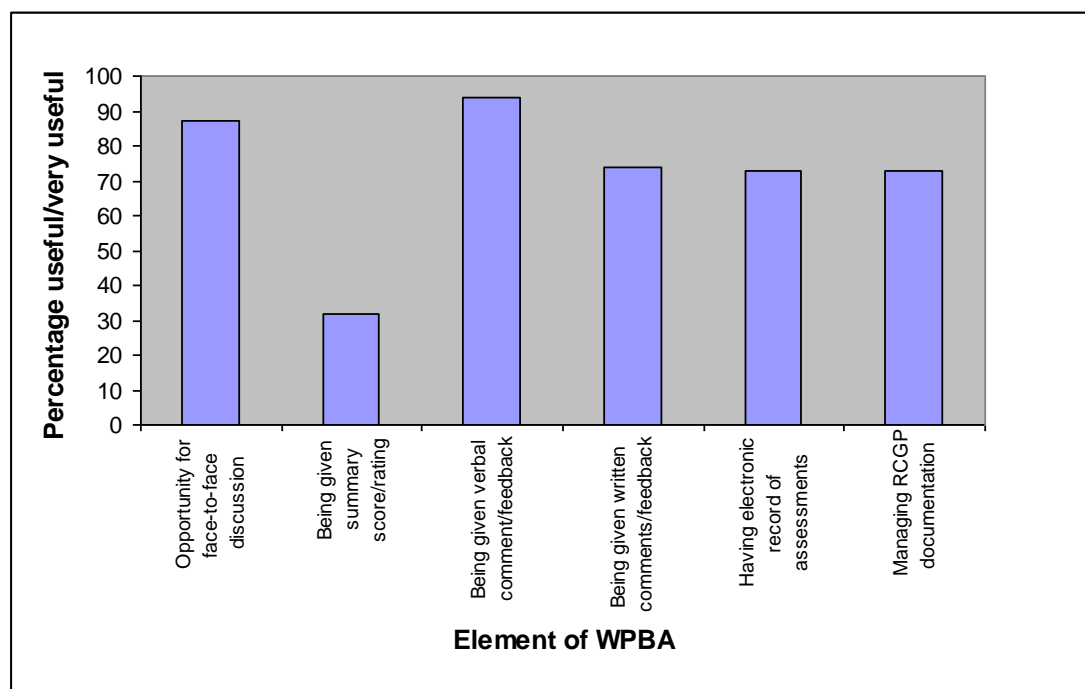*Figure 3. Trainees' views of usefulness of different elements of WPBA (as %)*

Table 5. Trainees' views of usefulness of being given written feedback, across the two training locations

Location of VTS	Usefulness of being given written feedback (% within location)		
	Not very useful/useless	**Useful/very useful**	**Total**
Location A	3 (12)	22 (88)	25
Location B	10 (40)	15 (60)	25
Total	13	37	50

Chi-square=5.094 (p=0.02)

## 4. What do trainees think about their assessors?

Data from questions relating to assessors reveal a number of aspects of assessment are working less well than the above statistics imply. Firstly, trainees in both centres are experiencing difficulties securing assessors for WPBA assessments with 85% of the sample reporting a problem with this,

mainly to do with finding a suitable person at the time and/or getting their agreement to do the assessment. Answers to questions about perceptions of the assessors' knowledge and skills are shown in Table 6 and Figure 4 below.

Table 6. Trainees' views of their assessors (frequency and %)

	Agree (%)	Disagree (%)	*Total*	Missing
Assessors seem to understand WPBA assessments	27 (53)	24 (47)	51	1
Assessors have sufficient knowledge of me/my practice	31 (61)	20 (39)	51	1
Assessors take sufficient time over the assessments	24 (47)	27 (53)	51	1
Assessors are good at giving verbal feedback	37 (72.5)	14 (27.5)	51	1
Assessors are good at giving written feedback	20 (39)	31 (61)	51	1

Figure 4. Trainees views of their assessors (as % agreement)
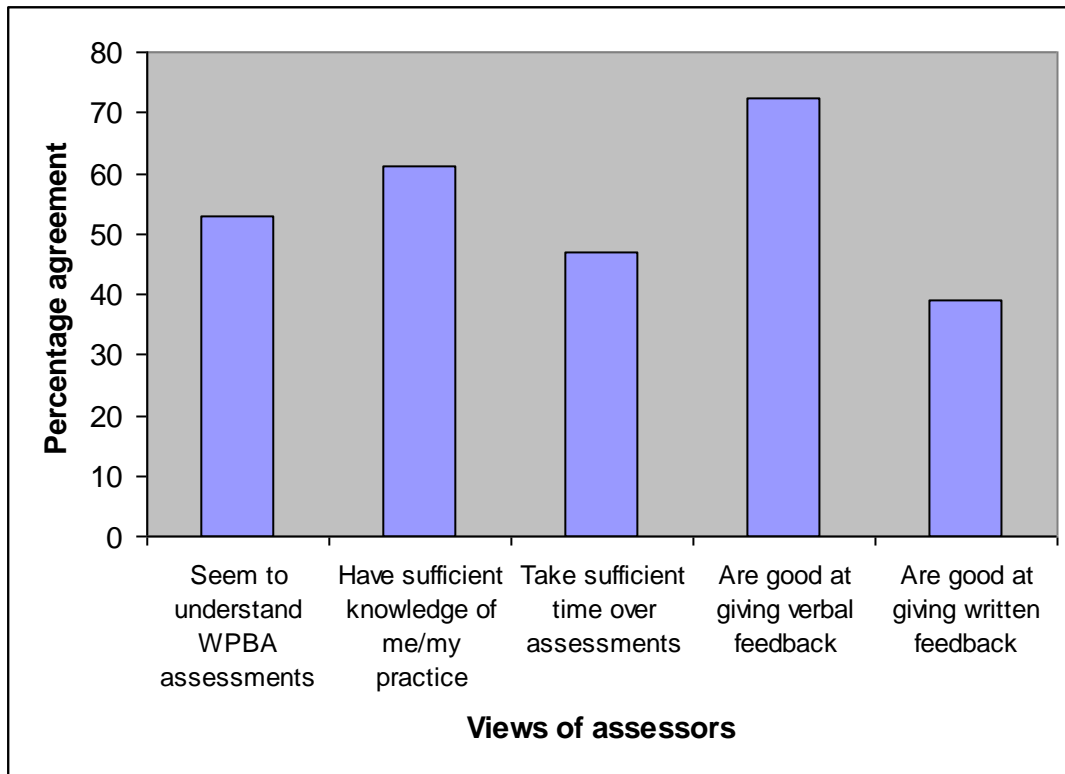
These data show that once an assessor has been secured, opinion is split as to whether assessors understand WPBA assessments. Just over half (53%) agree that they do but therefore 47% disagree with this statement. Trainees are also split as to whether assessors take sufficient time over assessments with almost half 47% agreeing and the remaining 53% majority disagreeing with this. The location of VTS was not found to be significantly associated with these variables. A clear impression of assessors is not achieved from this data. However, trainees do agree that assessors have sufficient knowledge of them/their practice (61%) and a clear majority agree that they are good at giving verbal feedback (72.5%) with no association with location of VTS. This contrasts with the finding that only 39% of trainees agree that assessors are good at giving written feedback.

This latter result stands in marked contrast to that in Table 4 above where trainees rated written feedback as useful. On further investigation (see Table 7) the data revealed that more trainees in location A agree that assessors are

good at giving written feedback (p=0.02) which links to the higher number of trainees in location A finding such feedback useful.

Table 7. Trainees' agreement that assessors are good at giving written feedback, across the two training locations

Location of VTS	Assessors are good at giving written feedback		
	Agree	**Disagree**	**Total**
Location A	14 (54)	12 (46)	26
Location B	6 (24)	19 (76)	25
Total	20	31	51

Chi-square=4.763 (p=0.02)

5. Use of rating scales/scores

Trainees were also asked about the use of rating scales/summary scores within assessments, and reported that assessors are not using the full range of the rating scales, with only 37% indicating that 'some or most assessors' use the full range. The majority of these trainees are based in location A and on further analysis a significant association was confirmed between location (A) and reporting that some or most assessors use the full range of the scoring scale during assessments (p=0.001) (see Table 8). It is interesting to note that, despite the reported narrow use of ratings, most trainees (76%) have not been given a score/rating they disagreed with, though perhaps this is a difficult question to answer honestly.

Table 8. Trainees' reported use of the rating scales by assessors, across the two locations

Location of VTS	Do assessors use the full range of the scoring/rating scale? (% within location)		
	Some/most	Few/none	Total
Location A	15 (58)	11 (42)	26
Location B	3 (13)	20 (87)	23
Total	18	31	49

Chi-square=10.468 (p=0.001)

6. Is WPBA found to be useful and valid?

Trainees were asked to indicate their agreement with four statements about the usefulness and value of WPBA overall. The data are shown in Table 9 and illustrated in Figure 5.

Table 9. What do trainees think of WPBA overall (frequency and %)?

	Agree (%)	Disagree (%)	*Total*	Missing
I find WPBA useful as a learning tool	28 (55)	23 (45)	51	1
WPBA can identify excellence in doctors	14 (27.5)	37 (72.5)	51	1
WPBA can identify a doctor who is struggling	23 (45)	28 (55)	51	1
WPBA will make me a better doctor	13 (26)	37 (74)	50	2

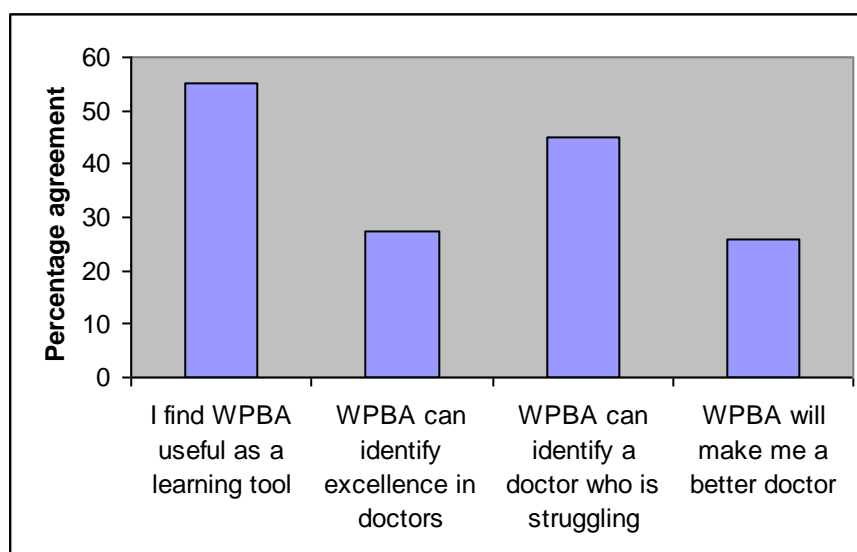*Figure 5. Trainees' views of WPBA overall (as % agreement)*

Table 9 and Figure 5 show that 55% of trainees agreed that they found WPBA useful as a learning tool and further analysis revealed an association with location of VTS with more trainees in location A (73% compared to 36% in location B) finding WPBA useful (p=0.008) (see Table 10). There was no association with year of training. This seems consistent with the findings explained above that more trainees in location A than in location B rate written feedback as useful, and agree that assessors give good written feedback; more of them find the CbD useful and report that some or most assessors use the ratings scales fully. This suggests that these factors may contribute to finding WPBA more useful.

Table 10. Trainees' views of the usefulness of WPBA as a learning tool, across the two locations

| Location of VTS	I find WPBA useful as a learning tool (% within location)		
	Agree	**Disagree**	**Total**
Location A	19 (73)	7 (27)	26
Location B	9 (36)	16 (64)	25
Total	28	23	51

Chi-square=7.076 (p=0.008)

A positive correlation was found between finding WPBA useful as a learning tool and agreeing that 'WPBA will make me a better doctor' (0.46 significant at p=0.01), which adds some credence to the findings above as it would be expected that something that is useful is also believed to make a positive difference. However the correlation is not particularly strong making it more complex to interpret; it perhaps suggests the system is only minimally useful so whilst on a personal level it may help to identify learning needs, overall this does not necessarily lead to better performance, just better understanding.

However, only a small minority (27%) of trainees agree that WPBA can identify excellence in doctors and a similar proportion (26%) agree that WPBA will make them a better doctor (with neither being associated with location of VTS or year of training). This time a stronger positive correlation was found between these two dimensions (agreeing that WPBA can identify excellence in doctors and that it will make them a better doctor, using Spearman's rho (0.58, significant at p=0.01).

A larger proportion (45%) agree that the system can identify a doctor who is struggling but the lack of a majority suggests that this sample of trainees is unconvinced as to the value of WPBA in raising standards.

The final question asked trainees whether WPBA is a valid judgement of competency. The strength of feeling is clearly illustrated in Figure 6 below.

Figure 6. Do trainees agree that WPBA is a valid judgement of competency (as %)?
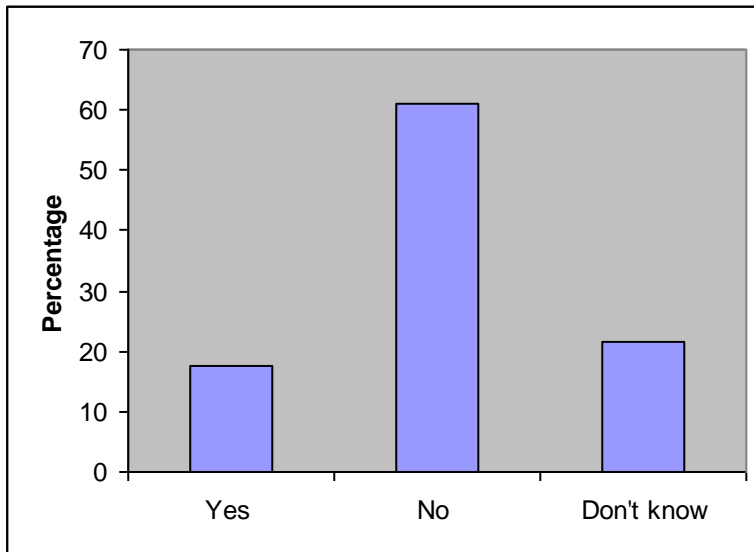
Overall, 61% of trainees did not think the assessments were a valid judgement of their competency, with a further 22% undecided about this. Interestingly, this variable was again associated with location of training with more trainees in location A responding positively (and responding don't know) to this question than in location B (p=0.003), as seen in Table 11. Again, the findings above may help to explain the difference in how valid the system is seen to be by trainees across the two centres.

Table 11. Trainees' views of validity of WPBA, across the two locations

Location of VTS	Are the assessments a valid judgement of your competency? (% within location)			
	Yes	**No**	**Don't know**	**Total**
Location A	8 (31)	10 (38)	8 (31	26
Location B	1 (4)	21 (84)	3 (12)	25
Total	9	31	11	51

Chi-square=11.605 (p=0.003)

Summary

The impression achieved from these data of how well WPBA is working is somewhat mixed. There are elements of the system that are clearly valued, namely the face-to-face contact created between trainees and senior colleagues, and the verbal discussion that takes place. There is also value placed on the potential at least, for more detailed and anonymous feedback in written form, such as from the MSF, with location A trainees rating this more highly than location B. And at a practical level the system offers a functional solution to the management of assessment records. However, the value of WPBA is reduced by difficulties in securing assessors; poor use of rating scales particularly in location B; variable experiences of written feedback, clearly less well delivered in location B than A; and poor selection of cases for the CbD assessment which limits rather than enhances what is learned. There are also weaknesses in the system from lack of time being spent on assessments; and some poor understanding of the system such that trainees are wrongly judged in relation to their current stage of training and not for the endpoint of GP training. Overall the weaknesses considerably impair the perceived validity of the assessments.

Some further insight into the challenges of WPBA was afforded from open-ended comments provided on the questionnaire.

Qualitative data from questionnaires

In addition to the quantitative data the questionnaires also generated a number of free text comments about specific tools, and overall about the validity of WPBA. Comments explaining the ratings given to specific tools can be described under positive and negative labels as follows:

Positive comments about tools: 49 trainees provided comments on the tool they rated at the most useful in the questionnaire giving insight into what features of assessment are most valued. Themes in these comments revealed that: the feedback element of the tools is highly valued, especially multi-source which is more anonymous (although one trainee commented

they would prefer to know who the feedback has come from); and related to this, the opportunity to talk through challenging cases and to learn/improve.

Negative comments about tools: 50 trainees provided further comments about their choice of the least useful tool. Themes in these comments were: lack of educational value of the assessments, nothing more than box-ticking, artificial/false; dependent on particular team; difficulties in securing assessors and time; assessments get in the way of everyday practice; many encounters not observed or assessments done incorrectly; not relevant to general practice; feedback comes too late in the placement to be useful. The remark 'Not fit for purpose' summarise the comments overall.

The following summary captures the themes in the comments made about the overall validity of WPBA:

38 trainees volunteered further comments on their response to final question about the validity of WPBA overall. The majority of comments were negative with almost no positive remarks made. Themes in this data were: system is dependent on the team and relationships with colleagues; also on the opportunities to work with seniors, as well as their commitment to the process which is required for assessments to be completed properly (one remark that trainees also lack commitment); no consistency in how completed; only a snapshot rather than accurate representation of overall competency; considerable bias from choosing cases and assessors – with people only saying 'nice things' or not being honest. The comment: 'wastes time and adds stress' is an appropriate summary of comments in this category.

These findings clearly expand and endorse the findings from the quantitative data and both were used to inform the design of the topic schedule in Phase 2.

Findings to explore in Phase 2

The findings of Phase 1 provided a strong evidence-base for the formation of topics for the focus group discussions. The following core topics resulted:

- What makes good written feedback?
- How are rating scales being used? How does this affect the valuing of WPBA?
- How could specific assessment tools be made more relevant to general practice?
- How could WPBA be improved?

Phase 2: Analysis of focus group and interview data

Prior to the analysis of the qualitative data, the transcripts from three focus groups and two 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. A thematic content analysis of the data was then undertaken facilitated by the use of the software package QSR Nvivo version 2.0. Following the work of Barbour (2007)[34], an initial stage of preliminary coding was undertaken by the lead researcher generating 12 top-level codes with each having two to four sub-codes. Two transcripts were coded independently by two further members of the research team. A high degree of consensus was seen in the interpretation of transcripts and the final coding frame was confirmed. After all data were coded the GP colleague on the team was given extracts of the coding report to assess the fit of the data with codes, with his agreement adding to the credibility of the analysis. Prior to the final write-up of the analysis, a trainee involved in the data collection was consulted on the interpretation of the phase 2 data as a form of respondent validation.[29] The comments provided were a strong endorsement of the findings from phase 2 and no changes were made.

Phase 2: Results

Of the 22 GP trainees who took part in phase two of the project, six were male and 16 female. Eight were currently in the first year of specialty training (ST1) and fourteen in the second year (ST2).

The findings from Phase 2 are described below under three main headings: problems with the system; problems with the assessment tools; and ideas for change relating to topics discussed. Under each of these are the themes and sub-themes emerging from the analysis. Quotes by trainees 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 trainee (using M or F), their year of training (ST1 and ST2) and training base location (either A or B). Other abbreviations used in this account are names of the four 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

CSR = Consultant Supervisor's Report

1. Problems with the system/process of assessment

1.1 **Feedback – verbal and written comments.** Feedback is highly valued especially in busier posts, and trainees in two groups talked of the value of feedback in providing reassurance and feeling appreciated. However, there are a number of problems that affect the quality of feedback:

1.1.1 Trainees talked of feedback often coming too late in the placement, leaving no time to act on it, giving the assessor little reason to comment on what should be improved. This limits "good constructive feedback" (F/ST2/A) so that what is given is "very little use because it's finished, it doesn't really matter" (F/ ST1/A). This was partly to do with trainees not focusing on assessment in the early part of a placement as they settled in, but also seemed to be related to workload, with 'busier

jobs' and certain specialties being linked with poorer feedback. The CSR and MSF were noted as providing some written feedback, with comments suggesting other tools generate only 'one or two lines' of written feedback.

1.1.2   Reference was also made in two groups and both interviews to the problem of getting many of the same comments across assessors and specialties, which one trainee termed as "just platitudes" (F/ST2/B) and another referred to as "vague and meaningless" (M/ST2/B). It is evidently a minority of assessors who offer to do an assessment resulting in better quality feedback, implicated in the force of this remark: "..occasionally you will get Registrars who will say 'oh you know, shall we do an assessment on that case?' And you think wow! And they do it and they will often write much more constructive comments that are more specific to you than the people that you go and nag essentially and those people are more few and far between". (F/ST2/A) More specific feedback with more individual comments would be valued by trainees.

1.1.3   Reflected in this and in other comments is evidence of poor attitudes among some assessors. One trainee (location B) referred to a case where an assessor had said all the trainees would be getting the same report, however well they did, they would all be rated competent. Another example from this group referred to a supervisor who signed her off after only a month on the grounds that "I know I'm going to have to do it..let's just get all your..paperwork over and done with." F/ST2/B) These comments illustrate how the system is not being adhered to in every case, affecting the quality of feedback given and received. In one group the trainees admitted at times they said themselves to assessors "it'll only take a few minutes" and "it's not a big deal, just write whatever" (both F/ST2/B), colluding with a tick-box attitude evident in the data (see section 1.2.2 below). Trainees in three groups referred to the potential for more responsibility to be taken by supervisors and consultants for assessment. This is discussed further in section 3 on changes.

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1.1.4 Verbal feedback is potentially more important in assessments like mini-CEX and CbD, especially in helping trainees who are not meeting standards, but remarks suggest this too is highly variable across assessors. Trainees value honesty but are doubtful about the level of honesty in some assessments. A link with anonymity was made here, in the sense that more anonymous feedback such as in the MSF is felt to be more honest. Trainees overall were highly sceptical of the honesty of verbal and face-to-face feedback as given in the Mini-CEX and CbD (even when there was the opportunity to write the comments down rather than verbalise them), with one trainee remarking "if everything was done face-to-face all you'll get are usually people praising you" (M/ST2/B) which typifies trainees' opinion on this (see also section 1.2 below on use of ratings/scores). There was conviction that a one-to-one scenario made it harder or even impossible to be honest, and trainees seemed to understand the pressure of being in front of someone: "it is really a big deal to be sat there next to someone while they're typing something about you in a box.' (F/ST2/B). One male trainee related this to the need to preserve working relationships, a theme picked up in section 1.3 below on bias. The MSF was raised by all groups and interviewees as the best tool for honest feedback making it the most useful assessment. (see section 2.3 below for more on the MSF)

1.2 Use of ratings/scores in assessments. It is clear from discussion arising in all groups that the rating scales within the assessments are not used in a consistent way by different assessors, giving rise to more variability in experiences of WPBA.

1.2.1 The main issue relates to whether an assessor is judging the trainee in relation to their progress to date (ie, for an ST1 or an ST2) or in relation to a qualified GP – the latter being how the scales are intended to be used. Many remarks suggest this is a significant weakness in the system as many assessors are confused and judging trainees on the basis of their progress to date and therefore not using the scale

correctly. This will reduce the comparability of scores across placements or across trainees which may be desirable at Deanery level. Comments were made about the inappropriateness of receiving a score of 'excellent' when this should not be possible in ST1 or 2, making it invalid as summed up by this trainee: "So you get these grades of excellent, but they're a bit meaningless because they haven't understood what's behind it." (F/ST2/B). Despite this many scores at the upper end of the scale are given. Other comments were made about being given 'excellent' against criteria which could not be assessed in hospital, for example, against the criteria 'Primary care admin and IMT' and 'community orientation'. One group (location B) in particular appreciated that hospital consultants were not best placed to judge expectations of a fully qualified GP. Related to this were comments about the use of 'insufficient evidence' which is avoided by assessors because "people don't like marking you down" (F/ST2/A). Some trainees themselves admitted to interpreting this rating as negative feedback even though they understood this could be appropriate in an assessment that did not give an opportunity to assess certain criteria, with one remarking: "It comes [across] just like you've done nothing" (F/ST1/B). In one group and one interview the simple solution to this was raised of including a 'not applicable' option. Comments suggest that training of assessors is perceived to improve problems with rating scales, with two groups and one interviewee referring to GP trainers who have been trained in the assessments and understand how the scales should be used. However, there was cynicism as to whether this was in the interests of trainees as "the more somebody reads the guidelines the worse marks they give you.." remarked a female ST2 in location B, who went on to imply that a certain amount of 'gaming' takes place: "so really it's in your interest to just find some random person..and say can you just tick a few boxes and they go, yeah, all right."

1.2.2   The data further reveal a perception of WPBA as being just a "box ticking exercise" (F/ST2/A), with similar phrases being used in all groups and interviews. Remarks about assessors ticking one category

such as 'meets expectations' "all the way down if they're that sort of person" (F/ST2/B), were typical among trainees, who clearly see that the assessments "say so much more about them than you really, …they are like haven't got time to do this for you, I'll just tick the boxes." (F/ST2/B). This clearly fuels a similar attitude among trainees who agreed in one group how "everyone plays it down..and it just becomes a complete tick box exercise…and nobody will ever look at it again" (F/ST2/B) and again later the same group admitted to feeling guilty about using somebody's time for assessment when it was just so that "the number goes green and you're ok for the next assessment." (F/ST2/B) suggesting it is viewed simply as a set of hoops to jump through. The benefit of reducing the volume of assessments (see section 3 below on changes) was linked with this.

1.3 **Bias.** A major source of bias in the system of WPBA is perceived to arise from trainees choosing their assessors.

1.3.1. Trainees openly admit to picking people they get on with to be their assessors, who will give positive feedback, as this ST1 explains: "people get it done by a friend who signs it off for them" about which she clearly states "I think it's totally invalid." (F/ST1/B). The loss of validity revealed in this remark is clearly evident in all the discussions that took place, summarised in this comment from an ST2: "if you do just get your mates to do it, then it's a waste of time." (F/ST2/A) with reference made by others to a lack of trust in the replies. A similar view was expressed in another group, which typifies the trainees as a whole: "The whole tool is completely flawed because you choose your assessors." (F/ST2/A) . The loss of validity from being able to get good feedback from friends appears to fuel the tick-box attitude described above, as seen here: "..ultimately that completes your aim which is to get your e-portfolio in order so that you pass your ARCP." (F/ST2/A). Just one trainee who was interviewed explained how she went to some trouble to pick people who she knew more on a professional than a personal basis, believing this to achieve more honest and more

constructive feedback. However, this did not emerge in other groups though one group did agree with an ST1 who had experience of consultants involving other staff in formulating their feedback which the group felt improved validity.

1.3.2. It was acknowledged in discussions that choosing people with whom the trainee got on well with was to some extent unavoidable as they had to pick people they had worked with over time. This makes solutions to this problem difficult but the idea of making the process of allocation more random was raised including consultants choosing assessors, an idea discussed in all groups (see section 2.3 where this is related to the MSF and see section 3 on changes) though there were concerns about the practicality of this.

2. Problems with the tools used in assessment

2.1 DOPS

2.1.1 Some trainees perceive DOPS to "be a big waste of time" (F/ST2/A) as they assess skills that have been signed off in Foundation, and in two groups admitted to not getting "someone to come along with you at the time" (F/ST2/A) or that "it's very rare that somebody watches you for all the bits that actually they're supposed to assess you for" (F/ST2/B), revealing some corruption of the system which undermines the value of this assessment. However, many trainees expressed a fairly pragmatic approach, with comments suggesting that DOPS are not a significant 'hardship' as one trainee put it, can build confidence and can in any case be left for the Registrar year. ST3 was recognised to have greater opportunities to be observed on more GP oriented skills by someone "in a much better position to actually watch you and say what you can and can't do" (F/ST1/B).

2.1.2 Trainees supported the idea of tailoring DOPS to include more GP oriented skills as mandatory, in particular, speculum examination, using a nebuliser, joint injections (though not all in this group felt this was a core competency for a GP), skin biopsies and six week baby check were mentioned. The idea of repeating more challenging skills to show

"that you can do it adequately on a number of occasions" (F/ST1/B), was supported, with up to 5 times being mentioned. One trainee linked the once-only basis of DOPS assessment to the "overarching problem" of WPBA being seen as just "an exercise required to progress" (M/ST2/B) (as per the tick-box approach discussed above), rather than a way of learning. As he put it: "there's a million things in medicine that you invariably get better the more you do and you should really only be signed off or assessed when you're good enough to do it, not on your first one.." (M/ST2/B). One group liked the idea of a log book, similar to that used by surgical trainees, filled in "on an honesty basis" (F/ST2/A), as a way to show evidence of competence.

2.2 Mini CEX and CbD

2.2.1   These assessments are considered together as trainees tended to refer to them together. The main theme here was that mini-CEX and CbD generate minimal feedback and are not highly valued because "invariably you'll pick a case that you've done well in or you know enough about.." (M/ST2/B), partly as this trainee explained, so as you don't feel stupid or uncomfortable, and partly as another trainee put it, so that you don't "get a bad mark" (F/ST2/A), which seems to be a motivating factor for these trainees, who are "programmed…to perform as well as possible and score as high as possible even if they know that they have other learning needs" in the words of one male ST2 (location B). As seen above with DOPS, viewing assessment in this way and limiting the learning by choosing cases that have gone well clearly impacts on the value of Mini-CEX and CbD. Simple changes such as making trainees select cases that have gone less well or getting the consultant to choose cases as "it would then be their teaching agenda…it would work a lot better if the consultants picked the cases", (M/ST2/B) would make these tools more useful and put the emphasis on learning rather than assessing.

2.2.2.   The loss of honesty from face-to-face contact, as mentioned above in section 1.1.4, was raised in connection with the poor feedback arising

from these assessments, with a typical remark being: "it's because you're sat with them, so they're not going to write necessarily honest comments." (F/ST2/A).

2.2.3. There was some support for making these assessments more challenging (see also section 3 below on changes to WPBA), for example, by having more detailed assessment of cases at the end of an attachment, though this will depend on having worked sufficiently closely with the consultant or assessor. This might help to mitigate some strong opinions expressed about mini-CEX and CbD which one trainee described as: "an absolute waste of time" (F/ST2/A) citing experiences of assessors wandering off half-way through. Time pressures were implicated in the reasons why these assessments tended to be combined and why they are often left to the last few weeks of a placement, and thus also in reasons for receiving only minimal feedback. The reluctance on the part of assessors was evident too, as here: "..it's difficult enough to get them even if they are just tick box exercises, sometimes it takes five minutes to get somebody to do it properly, it's a lot of time." (F/ST2/B). A system in which five minutes is considered too much time for an assessment is bound to suffer problems of quality and validity.

2.2.4 As with DOPS there is a need to tailor the CbD to fit with hospital based jobs for example, taking out questions on 'Community Orientation', and 'Primary Care Admin and IMT'. This remark was typical of trainees' views: "I know we're meant to be on a GP training scheme but at the end of the day you're doing a hospital post and you're seeing a hospital patient and it's a hospital based problem." (F/ST2/A). Doing these assessments in an outpatient setting was one suggested solution to this problem, as this is the most similar environment to general practice.

2.3 MSF

2.3.1. This assessment is highly valued because of the more remote format of feedback (ie, not face-to-face) which trainees linked to greater

honesty. It was perceived to be used for negative feedback more than other assessments, and because of the larger number of people giving feedback, to be more useful and valid. Again, comments were made about problems with choosing assessors and suggestions in all groups and interviews that this could be done randomly, with an example mentioned from one specialty where the consultant sent out the forms on behalf of the trainee. This would have the advantage of greater anonymity in the process, as seen in section 1.1.4 above and was widely supported by trainees. The idea of having a larger pool of people was mentioned too as "far more beneficial" (M/ST2/B), to overcome the influence of someone who "has a grudge or..you don't get on with" (M/ST1/B). Putting more emphasis on the MSF as a "more thorough review" (M/ST2/A) and perhaps reducing the number of other assessments "so everyone wasn't swamped with having to do those the whole time" (M/ST2/A), was suggested as a way to improve quality in WPBA.

2.4 CSR

2.4.1   Much less was said about the CSR than other assessments, with comments that trainees see this as more akin to the previous system of assessment meaning consultants are used to this type of discussion making it more useful. They are seen to get feedback from other colleagues to feed into the report, which generates more feedback than other assessments, both verbal and written. Linking with section 1.1.1 above the idea of having a CSR earlier on in a placement, to give an opportunity to review and act on feedback during a placement, was raised in one group. This could be triggered by staff sending their feedback to the supervisor early, or supervisors looking at portfolios which one trainee believed was meant to happen anyway, to see when to arrange a CSR.

3. Ideas for change

Overall, the trainees are highly critical of many aspects of the assessment process in hospital placements and the consistency of their views suggests considerable scope for improvement in the system of assessment, as well as to certain assessment tools. Trainees were asked to discuss ideas for changes which generated the following areas:

3.1 Changes to forms

3.1.1   There was wide support for adding a 'not applicable' option on the forms to overcome the problem with interpretation of 'insufficient evidence' highlighted in section 1.2.1 above.

3.1.2   Having separate forms for use in hospital placements emerged as a distinct theme. This would help overcome the problem of hospital doctors assessing GP trainees when they are not required to be familiar with the standards for a qualified GP, which was seen in section 1.2.1 above, to result in many assessors judging trainees for their current level of training and how well they are doing in that job, rather than in relation to a qualified GP. As this trainee questioned: "should hospital doctors really be assessing GPs, would you get GPs to assess hospital doctors? ..it does seem a bit odd." (M/ST2/B). Trainees are clearly sympathetic to the challenge faced by a hospital specialist assessing a GP trainee and would welcome a solution to this problem. A change to the form could clarify that the forms in hospital posts are to be used as per the Foundation Programme assessments, ie, assessing trainees for the level they are currently at, as in 'meets expectations' for an ST1 or ST2 in the given specialty. The idea of separate forms was also linked to the problem of trying to assess GP criteria such as 'community orientation' in hospital settings.

3.2 "Quality rather than quantity"

3.2.1   The theme of fatigue in the system was evident with trainees consistently raising the notion of fewer assessments in ST1 and ST2 with more opportunity for "qualitative" feedback, defined as open text,

"like a reference" (F/ST2/B). The CSR and MSF were mentioned in relation to this, as tools that give better feedback and should be retained, with DOPS, Mini-CEX and CbDs being minimised, and mainly used in ST3 where they are seen as more valuable. Reducing the frequency of filling forms and ticking boxes – the "numbers and ratings" as one trainee put it (F/ST2/B) – could help to overcome poorer attitudes to WPBA. As one ST2 remarked: "you have to change the attitudes by changing the process." (M/ST2/B). It may also improve quality in the process: "you'd get a lot more comments about the things that you might be able to improve on without having to have said fail or bad" (F/ST2/B). The link here to learning was made by one group: "the negative ones would be more positive in the sense that they would be more of a learning experience" (F/ST2/B). Building in more quality and promoting learning rather than pass/fail could also help overcome the issue mentioned in section 2.2.1 about playing into the hands of trainees who are programmed to pass tests.

3.2.2   A related theme of being more challenged by assessment was also evident in the data. One group favoured the idea of RITA (Record of In-Training Assessment) style assessment which would be "…daunting and I think that's what it should be…because then you take the process more seriously." (F/ST1/A) One interviewee supported this too, on the grounds that she could see how it would be "very easy to get through the first two years of General Practice, just by going into work every day and getting a few boxes ticked..and not really putting a lot of effort in.." (F/ST2/A). Overall, more challenge was linked to greater validity. Another interviewee supported the idea of more formal methods as in RITA type assessments, but simply on the grounds that a panel-based review can involve independent people which brings more rigour and can maintain standards, helping trainees in "finding deficiencies" and "setting targets" again, bringing more of a focus on learning (M/ST2/B).

3.3 Making the system more top down

3.3.1   A theme emerging from the issue of bias in the system concerned responsibility, and specifically about greater responsibility being taken by consultants for leading the assessment process. This includes the ideas in sections 1.3.2 and 2.2.1 above about getting consultants to allocate assessors, or at least some of the assessors that are used, to bring more objectivity and honesty to the system, and also getting them to choose cases for the CbD assessment. This would bring more formality to the process as well, with a consultant seen as bringing more "pressure to fill it in" (F/ST2/B) so making the system more efficient with less time wasted chasing up assessors to fill in paperwork. Trainees recognised the challenges of this in posts where the consultant is not involved in the day-to-day work of a trainee but the idea was popular.

3.4 Need for training

3.4.1   In section 1.2.1 training was seen as one solution to problems with the use of ratings/scores in assessment, with trainees citing GP trainers who have been fully trained in WPBA using the scales correctly and training being linked to more reliable feedback. However, the challenge of getting people to attend training is considerable with trainees able to predict that those who are motivated and enjoy it will attend but others who may most benefit from training will probably not. The lack of training undermines the perceived validity of WPBA as one trainee commented: "if the people assessing us haven't had training…surely the whole thing is completely invalid." (F/ST2/B). One group even cited assessors who had clearly not even read the guidance which is further evidence of the challenge of making change happen in WPBA through training.

3.4.2   Time has been mentioned in several sections above in relation to problems of poor quality in assessment, see for example, section 2.2.3. This is perhaps the greater challenge to overcome as trainees and

assessors are already stretched by WPBA in addition to their clinical duties and as seen above even now perceive just five minutes to be a long time to spend on assessment. However the unequivocal evidence that trainees are too often just spending "a minute with a consultant..so it comes down to just their instinct about you" (M/ST1/B) reveals how the system is not working as it was designed. To have integrity to the data revealed in this project, it must be asserted that assessors need to give more time to trainees and to take more time over assessments. If only in relation to giving assessors time for training, this must be acted on. One specialty (psychiatry) was highlighted in two groups as having more time for assessment with assessors quoted as having an hour a week so this is an area from which lessons can perhaps be learned.

Summary

What was striking during these discussions was the expectation among trainees that WPBA should be about helping them to become better doctors and their corresponding openness to feedback. However, expectations are dashed by a system that is seen to be open to bias and corruption, with assessors who are untrained and too busy, and which is thus failing to deliver high quality, honest feedback. In turn, the enormous potential benefit of helping trainee doctors learn from their performance is being lost.

The lack of honesty in the system becomes the overarching challenge. The tools, which are mostly designed for face-to-face feedback with the apparent etiquette accompanying this, limit the scope for honest feedback about skills and competencies. The element of choice in assessors and cases inevitably sees trainees making selections that will favour rather than challenge them and any motivation to buck this trend is lost in conformity. But the lack of honesty is also evident in assessors' conduct and attitudes which sees open corruption of the system such as completing assessments after only one month of an attachment and a tick-box, 'five minute' approach. A call for whistle-blowing was made forcefully by one trainee, which this data fully sanctions: "Because its just all the medical profession covering up and saying

we are all doing these assessments that are completely useless but we're signing each other off." (F/ST2/B). The clear signals for change seen here will inform the recommendations from this project.

Discussion

At the outset this project sought to achieve a clear picture of how WPBA is working day-to-day in hospital posts and, through its participatory approach, to generate useful suggestions about its improvement. Firstly, the data from the two phases of the project provide convincing evidence that the current system of workplace-based assessment for GP trainees does now need improving. Secondly, the data successfully achieve real insight into the problems being experienced to inform specific changes that might bring about such improvement. The conclusions offered here are particularly timely in view of the recent report of the Academy of Medical Royal Colleges calling for improvement in assessment across foundation and speciality training.[35]

What must not be lost in these findings is the considerable potential of WPBA in ensuring regular, structured discussions about performance are taking place between GP trainees and hospital clinicians with whom they seek to build a solid foundation for independent practice. And some of this potential is being delivered as many trainees rate face-to-face contact and verbal discussions as useful. But equally and unignorably, the data expose a clear message about a lack of honesty in assessments, which represents a serious threat to the validity and reliability of the system not necessarily captured in formal measurements of these qualities on which quality assurance relies. Furthermore, the lack of honesty is compounded by perceived poor practice among assessors in written feedback, use of ratings, and time taken over assessments with evidence of cursory box-ticking judgements; as well as poor practice among trainees in their selection of cases that by their own admission are not the ones from which they best learn. As Wilkinson (2007) reminds us, reliability in assessment 'comes from aggregating observations from a variety of situations'[11] which appears not to be happening here. The assessments thus become a set of hoops to jump through rather than a system for learning, which trainees themselves say they are programmed to pass but not encouraged to exceed.

All of these factors limit the learning that takes place in WPBA, and together with the notable lack of training of hospital assessors, hugely impair the perceived validity of the judgements that are made, regardless of any formal documenting of this aspect of the tools. Inevitably, and by trainees' own admission in phase 2, this negative perception feeds into continuing poor practice as a system that is seen to be flawed does not encourage adherence to its principles, perpetuating the problems.

The wider literature on WPBA in general practice is still limited at this stage but as implementation is relatively recent further studies can be expected. However, since the start of the present project the initial phase of a three-year evaluation of the new curriculum and training programme for GPs has reported its early findings which give credence to those reported here. The evaluation for the RCGP revealed 'wide variation in the quality of training provided in hospital posts …and many trainees..critical of how assessments were conducted in the hospital setting [which] were often not carried out correctly, and their formative potential not always realised.'.[36] The trainees reported difficulties in getting assessments completed, consistent with the finding here that 85% of trainees had difficulty with this, and also that there was a lack of standardisation among hospital assessors, who 'gave more of the higher ratings'. There were criticisms of the 'increased emphasis on assessment at the expense of learning', as seen here, with evidence of a 'tick-box approach'. Similarly, the evaluation has strong concordance with findings about the value of mini-CEX and CbDs which were 'seen to be dependent of the assessor's approach' and DOPS were similarly found to be unpopular as shown here. Findings were less conclusive about the MSF. The increasing burden on consultants from assessments was also highlighted and the need for more training in the use of the assessments.

Beyond general practice, a recent survey of UK dermatology trainees' views of the same WBPA tools by Cohen at al (2009),[37] further resonates with the findings of the present project. Cohen et al found that overall, trainees valued the potential for feedback and training opportunities from assessments, though not all reported receiving useful feedback, and common themes in

open-ended questions were problems with securing assessors and time factors such as 'rushed' assessments. The MSF was valued for the insight it provides. The importance of training sessions for assessors was implicated in solutions to the challenges of 'antipathy' towards WPBA.

Adding to the literature is evidence that these shortcomings of WPBA are now more widely acknowledged, with the Academy of Medical Royal Colleges referring to a 'crisis in assessment' in their recent report including mention of several of the issues highlighted here such as 'reductive 'tick-boxing' approaches' and loss of confidence in WPBA.[35] It is clearly timely to offer practical strategies to rebuild confidence in WPBA.

Recommendations for change:

It is appropriate to acknowledge that the system of WPBA for general practice is still considered to be in development[38] and many of the weaknesses found here are acknowledged by the Postgraduate Medical Education and Training Board itself, in its most recent 'Guide for Implementation'.[28] Therefore, the current project offers a number of practical suggestions, emerging from the data, to enhance the continuing development of WPBA in general practice and rebuild confidence in WPBA as follows:

At Deanery level:

1. Training for assessors in hospital posts – this is strongly implicated in the data seen here and elsewhere[17,21,37,35] and could help overcome the inconsistent use of rating scales as well as issues relating to time taken over assessments, incomplete observation of DOPS/mini-CEX and quality/depth of feedback that is more than 'just platitudes'. However, it is clearly unrealistic to expect all or even most hospital assessors to be trained. An additional practical response is to re-design certain tools to make them easier to use and more self-explanatory such that training is less urgently required.
2. Consultants should nominate at least some of the assessors on the MSF – this may help overcome criticisms of a biased system in which

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people choose their friends. More impartiality in the system could improve honesty in assessments and also improve response times for MSF feedback as the request would be top-down rather than bottom up.

3. Cases for CbD should include a wider range of cases including some that have not gone well, perhaps involving consultants in the selection of cases that introduce greater scope for learning and challenge. The documentation could prompt the assessor to comment on the level of challenge offered by the selected case.

4. Consider the role of specialist assessors within Trusts with protected time to manage WPBA to relieve pressure on consultants who are currently unable to give adequate time to assessment.

5. Identify dedicated trainers who can become expert in completing the six-monthly reviews and be given dedicated time to review the performance of a larger number of STs. This would ensure 'meaningful discussion of workplace assessment'[37] and help connect hospital-based training with general practice. GP trainers with one or two trainees may only complete two to four reviews per year, and are therefore unlikely to remain skilled in this part of assessment.

At RCGP level:

6. Reduce the number of assessments in hospital posts with more emphasis on qualitative feedback to help relieve pressure on both trainees and assessors during ST1 and 2. This could help to make poor quality, rushed or incomplete observations less likely, particularly in mini-CEX/CbD/DOPS. It could also allow greater time and emphasis on those assessments that are particularly valued for the depth of qualitative and honest feedback they provide, such as the MSF. A similar call for assessments that rely on qualitative information is made by Van der Vleuten and Schuwirth (2005) in their discussion of assessment programmes. Whilst in theory a high number of assessments gives greater confidence in the results, the reality of poorly conducted assessments clearly undermines this.

7. Adjustments to tools so that there is less use of tick-boxes and more opportunities for comments such as *'what went well?'* or *'what could have been done better and how?'* would also encourage more specific feedback which trainees clearly find more useful.

8. Related to 6 above, complete DOPS in the ST3 year only to take pressure off assessments whilst in hospital posts and also because this is where particular procedures relevant to general practice should be assessed. Also, move from 'once-only' approach to competence to repeated assessment for more challenging procedures such as speculum examination.

9. Modify WPBA forms for hospital posts either so that these do not refer to criteria that can less commonly be assessed in a hospital post or so that those criteria are labelled as 'optional'. This could improve the perceived validity of the assessments in hospital and lead to more meaningful feedback.

10. Expand the 'insufficient evidence' box to include 'not applicable', 'not assessed', or 'poor' to overcome the problems reported here of misuse of this category and even avoidance because of the negative connotations.

11. Consider the place for more challenging assessment methods such as the panel-based assessments used in RITA, at appropriate points during training. RITA is used alongside WPBA in dermatology training.[37]

12. Change the basis of assessment in hospital posts to be for stage of training, not GP endpoint, to be consistent with Foundation Training. Include clear instructions about this on the form to remind all assessors at the time of assessment.

Conclusions

This project has successfully captured the views and experiences of a current cohort of GP trainees working in hospital posts as they complete WPBA. It has found enormous potential value in day-to-day assessments with many trainees gaining useful feedback from their colleagues. Nonetheless, the

system overall is not working as it could to deliver consistently high quality, objective and constructive feedback on performance from which trainees could not only learn but continually improve their practice. WPBA is still in development and this project offers some timely strategies for making changes for the better. Given the challenges uncovered in managing the vast number of assessments taking place in hospitals each day the findings add weight to the call by Mamelok (2009) for a 'robust framework for quality assurance'[38] within WPBA.

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Appendices

Appendix A: Questionnaire

NHS

Education South West
Severn Deanery

UWE University of the
West of England
BRISTOL

Workplace Based Assessment in Severn Deanery
Questionnaire for Trainees

This questionnaire is about your experiences of workplace-based assessment during your GP training **in hospital posts**. Please complete all questions that apply to you and return to the researcher in attendance today (or see address at end of form). All responses you provide will remain anonymous and confidential. Thank you for your time.

About you:

1. In which year of your GP training are you?

Year 1 ☐   Year 2 ☐

2. What is the location of your Vocational Training Scheme?

Bristol ☐   Bath ☐

3. Please tell us your gender:

Male ☐   Female ☐

4. Please tell us your age:

<25 ☐   25-34 ☐   35-44 ☐   45> ☐

5. Years since qualification at Medical school:

_____

6. Prior to starting your GP training were you part of a Foundation Programme?

F2 only ☐   F1 and F2 ☐   Not in a Foundation Programme ☐

7. How **useful** do you find each of the
WPBA tools used in hospital posts?
Please rate each one between 1 and 5:

1= Useless   to   5= Very useful:

a. Case-based Discussion:	1	2	3	4	5
b. Mini-CEX:	1	2	3	4	5
c. DOPS:	1	2	3	4	5
d. Multi-source feedback:	1	2	3	4	5
e. Clinical supervisor's Report:	1	2	3	4	5

8. Please state what makes your highest ranking tool(s) the most useful?
_____

_____

9. Please state what makes your lowest ranking tool(s) the least useful?
_____

_____

10 How do you rate the WPBA
area of the e-portfolio?

	Excellent	Good	Average	Poor
a. Reliability of access	☐	☐	☐	☐
b. Ease of navigation	☐	☐	☐	☐
c. Clarity of instructions	☐	☐	☐	☐
d. Performance (e.g. entering/ saving changes, saved assessments appearing in record, etc.)	☐	☐	☐	☐

Any comments on the e-portfolio: _____

_____

11. Which of the following do you find
useful in WBPA?

	Very useful	Useful	Not very useful	Useless
a. The opportunity for face-to-face discussion	☐	☐	☐	☐
b. Being given a summary score or rating on each assessment tool	☐	☐	☐	☐
c. Being given verbal comments/ feedback	☐	☐	☐	☐
d. Being given written comments/ feedback	☐	☐	☐	☐
e. Having an electronic record of assessments/skills/competencies	☐	☐	☐	☐
f. Managing documentation required by the RCGP	☐	☐	☐	☐

Other - please explain: _____
_____

---

12. Do you think WPBAs assess
additional competencies to those
tested in the Foundation Programme?

	Yes	No	Not applicable
a. Case-based Discussion:	☐	☐	☐
b. Mini-CEX:	☐	☐	☐
c. DOPS:	☐	☐	☐
d. Multi-source Feedback:	☐	☐	☐

About your assessors in hospital posts:

	Yes	No
13. Have you ever had difficulty securing an assessor for WPBA?	☐	☐

13.1 **If yes**, what was the nature of the problem? (you may tick more than one)

Finding a suitable person at the time	☐
Getting the agreement of a suitable person/securing their time	☐
Getting access to the e-portfolio forms at the time of the assessment	☐

Other – please specify: _____

14. How far do you agree with the following statements:

	Strongly Agree	Slightly Agree	Slightly Disagree	Disagree
a. Assessors seem to understand WPBA assessments	☐	☐	☐	☐
b. Assessors have sufficient knowledge of me and my practice to judge competency	☐	☐	☐	☐
c. Assessors take sufficient time over the assessments	☐	☐	☐	☐
d. Assessors are good at giving verbal feedback	☐	☐	☐	☐
e. Assessors are good at giving written feedback	☐	☐	☐	☐

15. In your experience, do assessors in hospital posts use the full range of the scoring/rating scale when assessing GP trainees?
(e.g. from '*below expectations*' to '*above expectations*' or '*poor*' to '*excellent*')

Please select the answer that most accurately reflects your experience:

Most assessors use the full range of the scales ☐

Some assessors use the full range of the scales ☐

Few assessors use the full range of the scales ☐

None of the assessors use the full range of the scales ☐

16. Have you ever been given a score or rating that you disagreed with?	Yes ☐	No ☐	
16.1 **If yes**, was it:	Too high ☐	Too low ☐	Prefer not to say ☐

17. Which of the following is **most** true for you?

When selecting cases for the CbD assessment, I tend to select cases that have gone well ☐

When selecting cases for the CbD assessment, I select a mix of cases that have gone well, and those that have not gone well ☐

When selecting cases for the CbD assessment, I tend to select cases that have not gone well ☐

---

18. In your day to day practice, which type of cases do you think you learn most from?

a. Cases that go well ☐   b. Cases that do not go well ☐   c. It depends on the case ☐

---

19. How far do you agree with the following:

	Strongly Agree	Slightly Agree	Slightly Disagree	Disagree
a. I find WPBA useful as a learning tool	☐	☐	☐	☐
b. WPBA can identify excellence in doctors	☐	☐	☐	☐
c. WPBA can identify a doctor who is struggling	☐	☐	☐	☐
d. WPBA will make me a better doctor	☐	☐	☐	☐

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20. Overall, do you think that the assessments are a valid judgement of your competency?

Yes	No	Don't know
☐	☐	☐

Please comment on your answer: _____

_____

_____

Thank you for taking the time to complete this questionnaire. Please hand back to the researcher in attendance today or by post to: Abigail Sabey, UWE, Faculty of Health and Life Sciences, Hartpury Campus, Gloucester GL19 3BE.

University of the
West of England
BRISTOL

Information Sheet for Participants

Project: Evaluation of Workplace-based Assessment with Severn Deanery GP trainees

You are being invited to take part in a research study. Before you decide 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 evaluate the current system of workplace-based assessment (WPBA) for GPs, with GP trainees from the Severn Deanery. The aim is to capture the current experiences of trainees with WPBA including (i) practicalities of undertaking assessments; (ii) understanding of the process including standards for assessment; and (iii) views about potential improvements to the system. The study has been approved by UWE Faculty Research Ethics Sub-Committee at their meeting on 28th October 2008.

Why you have been chosen:

You have been chosen to take part in this research because you are a GP trainee at one of the centres within Severn Deanery, currently undertaking WPBA. In total, approximately 170 trainees drawn from two locations within the Deanery will have the opportunity to take part in the research.

If you do not wish to take part:

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your position in any way or your assessment marks or any aspect of your training.

What will happen if you decide to take part:

You will be given a questionnaire to complete during your regular education day. To minimise any inconvenience to you, you will be able to complete and return the questionnaire at that time (or you may pass it to your GP facilitator for return). The questionnaire will be

anonymous and all data will be kept entirely confidential (see also the later section on confidentiality). The questionnaire will also include an invitation to express your interest in taking part in a focus group to discuss some of the issues related to WPBA with other trainees. This invitation can be separated from the questionnaire so that your data remain anonymous. (If you are selected to take part in a focus group, a separate and information sheet and a consent form will be given to you in advance).

The answers you provide in the questionnaire will be analysed with other questionnaires and the collated findings will contribute to the design of the focus group enquiry, as well as form the basis of conclusions from the research. The research study as a whole is planned to take place across twelve months.

The possible disadvantages and risks of taking part:

No adverse effects, risks or hazards are anticipated from completing the questionnaire.

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 questionnaires will be anonymous and your name will not appear on any documentation. Only the project manager will have access to names of respondents who take up the invitation to attend a focus group. Questionnaires will be stored in a locked cabinet at the workplace of the project manager, to which only she will hold the key, 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 GP trainees 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.

Abigail Sabey, 5th November 2008
Version 2

University of the
West of England

BRISTOL

Information Sheet for Focus Group Participants

Project: Evaluation of Workplace-based Assessment with Severn Deanery GP trainees

You are being invited to take part in the next stage of this research study following your expression of interest. You may have completed a questionnaire for this study at an earlier stage. 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 evaluate the current system of workplace-based assessment (WPBA) for GPs, with GP trainees from the Severn Deanery. The aims are to capture the current experiences of trainees with WPBA including (i) practicalities of undertaking assessments; (ii) understanding of the process including standards for assessment; and (iii) views about potential improvements to the system. The first phase of the study which you may recall, used a questionnaire and the next phase proposes to use focus groups to explore some areas in more depth. The study has been approved by UWE Faculty Research Ethics Sub-Committee at their meeting on 28th October 2008.

Why you have been chosen:

You have been chosen to take part in this research because you are a GP trainee at one of the centres within Severn Deanery, currently undertaking WPBA. You have indicated an interest in taking part in further stages of the research involving a focus group.

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. A decision to withdraw at any time, or a decision not to take part, will not affect your position in any way or your assessment marks or any aspect of your training.

What will happen if you decide to take part:

You will be sent a reminder of the date, time and venue of the focus group. You will attend with up to seven other participants, all trainees at the Deanery. The group will be facilitated

by the project manager (or other senior researcher from UWE) and a research administrator will also be present to record notes.

Each focus group is expected to last up to one and a half hours and will be based around particular issues related to workplace-based assessment highlighted by trainees in the questionnaire. This is intended to be a group discussion related to WPBA and not in any way an assessment activity itself. Your permission will be sought to audio-tape the focus group but the discussion, taped record and any other notes will be kept entirely confidential (see also the later section on confidentiality). The information arising from the focus group will be analysed with data from other 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 twelve months

The possible disadvantages and risks of taking part:

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

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 focus groups will be anonymised and your name will not appear on any documentation or recording. Only the researcher and research administrator attending the focus group will have access to names of participants. Transcripts, tapes and notes will be stored in a locked cabinet at the workplace of the project manager, to which only she will hold the key, 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 GP trainees 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, 5th November 2008
Version 2