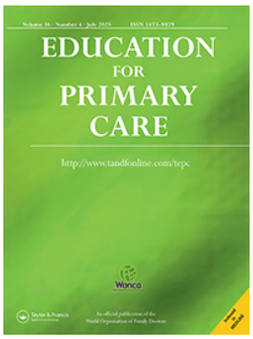

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RESEARCH ARTICLE

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Experiences of UK general practice trainees undertaking workplace-based assessment who received a developmental outcome at their annual review of competency progression

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ABSTRACT

Background: Workplace-Based Assessment (WPBA) forms part of the integrated assessment system for UK General Practice (GP) licencing. An Annual Review of Competence Progression (ARCP) panel evaluates either satisfactory progress or requirement for development of specific capabilities. We aimed to explore GP trainees' experiences of undertaking WPBA when failing to progress by receiving a 'developmental' outcome 2 or 3.

Methods: We used a qualitative design employing Systematic Grounded Theory and semi-structured interviews. A purposive sample of GP trainees was recruited, at different stages of training and with varying demographic characteristics, who had a previous ARCP developmental outcome. Interviews were recorded, transcribed verbatim and analysed, facilitated by NVivo 14.

Results: We interviewed 20 GP trainees during 2024 who received a developmental outcome between 2020 and 2023. We identified five themes: 'potential for early intervention', included personalised support and better information provision; 'perceptions of how WPBA reflected trainee performance' including perceptions of the validity and reliability of WPBA and need for fair, trustworthy and transparent processes to reduce unfair discrimination; 'communication difficulties' arose in relation to culture, language and reflection for some study participants; 'relationships with peers and educational setting' were felt to affect performance; and some participants experienced negative 'effects on wellbeing'.

Conclusion: Suggestions aimed at supporting and overcoming potential challenges to undertaking WPBA during GP training, including personalised support, reviewing fairness of assessments, addressing communication and cultural barriers, enhancing training environments, fostering positive relationships, and mitigating negative wellbeing impacts, some of which were already in place, with others requiring development.

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Introduction

Workplace-Based Assessment (WPBA) forms a key component of the Membership of the Royal College of General Practitioners (MRCGP) licencing assessment for General Practitioners (GPs) in the United Kingdom (UK) [1]. WPBA uses a range of assessment tools to evaluate GP trainees' progress (see Box 1) which showed evidence of validity and reliability prior to their introduction [2,3]. Previous validity assessment of WPBA in current use for UK GP training has been limited to perceptions of trainees and trainers on WPBA [4] and the reliability of individual WPBAs [5,6]. A survey of trainees and trainers found both were largely positive towards WPBA, although qualitative analysis of free text responses revealed concerns about validity and relevance, burden of assessment, fairness and potential for bias against candidates with protected characteristics [4]. Reliability has been difficult to assess for WPBA because of difficulty accessing data but where this has been done on relatively small numbers of trainees the consistency of judgements between assessments was poor, particularly for case-based discussions [5] and multi-source feedback [6].

GP trainees in the UK present a portfolio of WPBAs and other evidence for review by an Annual Review of Competence Progression (ARCP) panel during each year of training [7]. The main determinant of ARCP decisions

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Box 1. Abbreviations and types of WPBA tools in general practice.

- **Mini Clinical Evaluation Exercise (MiniCEX)**: A MiniCEX is an observed, real-life, interaction between a trainee and patient. The MiniCEX assesses clinical skills, attitudes and behaviours. The MiniCEX is completed in the non-primary care setting.
- **Consultation observation tool (COT)**: The COT is an expanded version of the MiniCEX and considers trainees consultations with real patients during primary care placements. The Audio-COT provides an additional tool to enable the assessment of telephone consultation skills.
- **Clinical Examination and Procedural Skills (CEPS)**: The CEPS assessment records evidence against the CEPS capability and assesses whether the trainee is competent in clinical examinations and procedures. By the end of training, they should demonstrate competence in five GMC-mandated 'intimate' CEPS and a range of other CEPS (such as respiratory system or musculoskeletal system assessment) relevant to GP.
- **Case-based discussion (CbD)**: The CbD is a structured oral interview designed to assess professional judgement in a clinical case. The assessment assesses performance against the capabilities and looks at how holistic, balanced and justifiable decisions are made in relation to patient care. It assesses understanding and application of medical knowledge, ethical frameworks, ability to prioritise and how complexity and uncertainty of the consultation were approached.
- **Multisource feedback (MSF)**: The MSF tool is used to collect colleagues' opinions on trainees' clinical performance and professional behaviour. It provides data for reflection on performance and self-evaluation.
- **Patient Satisfaction Questionnaire (PSQ)**: The PSQ provides patient feedback on a trainee's empathy and relationship-building skills during consultations.
- **Quality improvement project (QIP)**: Measures a learner's ability to successfully conduct a quality improvement project. Various descriptors for the assessment of this competency could be topic selection, identification of the right criteria/measures, methodology used, changes implemented, evaluation of change and future implications, presentation skills and quality of project in general. Feedback is provided based on the given criteria.
- **Leadership Activity and Multi-Source Feedback (LMSF)**: The leadership-focussed MSF is designed to obtain feedback on a trainee's leadership skills. It can be used for the assessment of the learner's organisational skills, owning of responsibility, effective management of team, etc.
- **Clinical supervisor report (CSR)**: The Clinical Supervisor Report (CSR) is a short, structured report completed by the Clinical Supervisor in each post where they record observations on a trainee's performance.
- **Educational supervisor's review (ESR)**: Periodic review by the educational supervisor to assess overall progress, identifies area of focused input and feedback, based on performance on various WPBA tools and 'naturally occurring evidence'.

is WPBA performance but occasionally they are influenced by other factors including endpoint assessments such as the Applied Knowledge Test. ARCP decisions include Outcome 1 (Achieving progress and capabilities at the expected rate), Outcome 2 (Development of specific capabilities required – additional training time not required), Outcome 3 (Development of specific capabilities required – Additional training time required), Outcome 4 (Released from training programme with or without specified competences), Outcome 5 (Incomplete evidence presented – An assessment of progression cannot be made) and Outcome 6 (Achieved all required capabilities for completion of the programme, will be recommended for award of a Certificate of Completion of Training) [7]. We use the term 'developmental' outcome, to include outcomes 2 or 3, for this study, where trainees require further development of specific competences with or without additional training time.

As medical education moves towards capability-based education, which focusses on personal growth, agency and social justice [8], WPBA has become increasingly important for enabling trainees from a wide variety of backgrounds to reflect on their day-to-day practice and receive high-quality feedback to achieve capability standards. The process by which trainees perform WPBAs, present reflections on clinical practice in their training portfolio, and supervisors or others provide feedback on these and other evidence, are core aspects of WPBA [9]. Constructive regular feedback on trainees' professional development is widely accepted as beneficial [10], particularly when feedback is from a source they perceive as credible [11]. Trainees' and educational supervisors' engagement in and perceptions of the assessment process are crucial for its usefulness [12,13].

Self-regulation theory [14] suggests that learners thoughts and behaviours before and during, as well as reflection after learning activities, can have important effects on performance [15]. Previous studies, expanding on this idea, suggest that there are internal (from trainees) and external (from evaluators or the wider system) factors that affect trainee outcomes in WPBA, including their personal engagement in self-monitoring and self-regulation, more rapid feedback of results [16], reducing the complexity of feedback (focusing on achievements, safety or prevention of risks) [14], and increasing supervisor credibility and trainees' commitment to change, time, physiological needs, resources and skills [13].

Previous studies have focussed on common barriers to successful implementation of WPBAs, including lack of assessor time for engagement, training and calibration [17], inconsistency and need for standardisation in processes for feedback [18], supervisor bias, subjectivity and trust [19], and unfairness in learning environments [20,21]. Other studies draw attention to specific challenges for trainees undertaking WPBA such as the impact of specific learning difficulties [22], and causes of differential attainment, particularly among International Medical Graduates (IMGs) [23,24].

Although WPBA is widely accepted and used, there are knowledge gaps in the areas of (1) their effective use during placements [25]; (2) the extent of the differential attainment gap in WPBA and the reasons for this [23,26] and (3) lack of evaluations of interventions to reduce differential attainment [23,27]. There is a need for research to understand the experiences of WPBA,

particularly in doctors who are having difficulty with progression at the ARCP.

Aim

We aimed to explore the experiences of GP trainees who had failed to satisfactorily progress at ARCP having been awarded an Outcome 2 or 3, on their perception of undertaking WPBAs, their thoughts on why they had been awarded a developmental outcome as well as their suggestions on what may have helped prevent this.

Methods

Design

We used a qualitative design employing Systematic Grounded Theory (SGT) [28] consisting of inductive methods to inform theory development.

Systematic grounded theory

The inductive approach was used to build on existing knowledge and further our understanding around the difficulties of GP trainees completing the WPBA. We used the SGT approach [28] to understand the experiences of WPBA, perceived challenges, strategies for overcoming these and solutions. SGT allows the incorporation of existing knowledge to build theory [28]. Analysis included open, axial, and selective coding [28] prior to the theory stage (Box 2). We validated theoretical statements in the emerging theory by collecting new data with theoretical sampling logic, continuing coding until we reached theoretical saturation [29].

Reflexivity

We employed a double hermeneutic technique, meaning the participant interpreted the significance of their own experience and the researcher, in turn, made interpretations about what was represented in the interview. The research team included experts in qualitative research (JA, SE, JP) and GPs with a background in education and assessment (KE, BS, SM, AW, AK, NS) and with experience in qualitative methods (NS). KE was WPBA lead for the RCGP during the study. NS was a GP with a background in education and assessment who at the time of the study was research lead for assessment for the RCGP and had undertaken several studies on differential attainment in GP licencing examinations including for doctors with specific learning differences. These experiences and background were acknowledged during the conduct of the study while following the theoretical approach and analytic methods described [30].

Recruitment and participants

In 2023/24, we recruited a purposive sample of GP trainees. Between 1 August 2022 and 31 July 2023 there were 19,620 ARCP Outcomes awarded, of which 537 were Outcome 2 and 1,758 were Outcome 3. The study was advertised through the trainee portfolio, and snowballing was used, with participants already identified, assisting in recruitment of further eligible participants to the study.

Interviews and analysis

Participants contacted researchers (JA, SE, JP) via email to express interest, receive further information and give informed consent. Researchers (JA, SE, JP) arranged individual interviews online via MS Teams. All participants were given a unique number for anonymity and were informed that data may still be used in the analysis if they withdrew from the study. Data were collected during 2024 using semi-structured interviews guided by an interview schedule (Supplementary file S1) and lasted 40–70 min. Interviews were audio-recorded, transcribed verbatim and analysed using SGT [22,23] (Box 2) facilitated by NVivo 14. Initial coding was undertaken by two researchers (JP and JA) and detailed codes, themes and sub-themes were developed iteratively through a series of monthly discussions with the whole team, during and beyond the period of data collection. Interview questions and data collection were adjusted in response to emerging information and analysis stopped when data saturation was reached in codes and meaning [29].

Box 2. A Straussian framework showing methods and principles guiding analysis.

Initial coding	Open coding Use of analytic technique Guides the researcher where to focus further analysis
Intermediate phase	The four stages of axial coding: (1) continually relating subcategories to a category (2) comparing categories with the collected data (3) expanding the density of categories by detailing their properties and dimensions (4) exploring variations in phenomena
Final development	Selective coding Detailed development of categories, selection of core, integration of categories
Theory stage	A detailed account of the process fully described.

Results

We interviewed 20 GPSTs including four UK graduates at different stages of training and demographic characteristics who had a previous ARCP development outcome of 2 or 3 in 2020 to 2023 (Table 1).

Five themes and several subthemes were identified from the analysis (see Box 3).

Theme 1 potential for early intervention in WPBA

Early support and protected time

Early opportunities to support learning were felt by some participants to be missed and with attempts to resolve participants' educational difficulties happening late in training or during extensions. Reasons for participants struggling varied, such as a lack of understanding of the assessments, problems navigating the portfolio, or failure to provide a culturally sensitive approach.

> I think I understood the training mostly when I started having these outcomes. I've had outcome 3 three times and I've been on extended time since 2020. I should've figured it out in my first three years, that's the sad bit . . . (P6 IMG)

More protected time and additional time for professional development were felt to be needed.

> So, I think if you had protected time specifically for WPBAs, then that would mitigate that difference in trainer (more familiarity). (P20 UKG)

Personalised and tailored approach to induction and supervision

It was perceived that an explanation of WPBA during induction would have been helpful.

> No, there's no formal training, to be honest, what would be very handy is formal teaching on the portfolio and what needs to go into it at the very start of GP training, which I didn't get. . . . . I don't think I had much of an induction, if any, to be honest. (P15 UKG)

Participants who were IMGs were unfamiliar with the UK training system and felt that UK graduates had more experience with WPBA.

> I think every trainee should get an opportunity to learn about WPBAs, especially the international medical graduates who hardly ever have any clue about these WPBAs. They usually have an induction alongside the induction when they are rotating to primary care, but they should be actually given an opportunity to learn about the WPBAs in detail, in

Table 1. Participant characteristics.

ID	Age group	Gender	Ethnicity	Primary Medical Qualification: *UKG/IMG	Full time (FT)/Part time (PT)	Type of SpLD	Year of training (1–3)	Last ***ARCP outcome
P1	30–34	M	Arabic	IMG	PT	None	1	2
P2	40–44	M	Asian	IMG	FT	Dyslexia	3	3
P3	30–34	M	Asian	IMG	PT	None	3	2
P4	45–49	F	White British	UKG	PT	Dyslexia/ **ADHD	3	3
P5	45–49	M	Asian	IMG	PT	None	3	3
P6	40–44	F	Asian	IMG	FT	Dyslexia	3	3
P7	30–34	M	Arab	IMG	PT	None	1	3
P8	35–39	M	Black African	IMG	FT	None	3	2
P9	40–44	F	Asian	IMG	PT	None	3	3
P10	Not given	F	British Asian	IMG	PT	Not disclosed	2	3
P11	40–44	F	White other	IMG	FT	ADHD	3	3
P12	35–39	F	British Asian	IMG	PT	None	2	2
P13	45–49	M	British Asian	IMG	FT	None	3	3
P14	35–39	M	Arab	IMG	FT	Dyslexia	3	2
P15	35–39	M	White British	UKG	PT	None	3	2
P16	40–44	F	Asian	UKG	PT	None	3	3
P17	35–39	M	Arab	IMG	PT	Dyslexia	3	2
P18	40–44	F	White other	IMG	PT	None	3	3
P19	45–49	F	White Other	IMG	FT	None	2	2
P20	35–39	M	White British	UKG	FT	None	3	2

*UKG/IMG: UK Medical Graduate/International Medical Graduate.
**ADHD: Attention Deficit Hyperactivity Disorder.
***ARCP: Annual Review of Competence Progression.

Box 3. Core themes andsubthemes.

- **Theme 1 Potential for early intervention in WPBA**
  - Early support and protected time
  - Personalised and tailored approach to induction and supervision
  - Provision of information to improve
  - Missed opportunities/failure to support
- **Theme 2 Perceptions of how WPBA reflects trainee performance**
  - Validity, reliability and consistency
  - Fairness, trust, and transparency
  - Discrimination
  - Identifying challenges with specific WPBAs
- **Theme 3 Communication difficulties affecting WPBA**
  - Cultural approach
  - Language
  - Reflection
- **Theme 4 Relationships, educational setting and their effect on WPBA**
  - Relationship with supervisors, deanery, peers and patients
  - Effect of setting on trainee experiences of WPBAs
- **Theme 5 Effect of WPBA on wellbeing**
  - Feelings of stress
  - Low morale
  - Personal factors outside work affecting trainee performance

> discussion with his or her educational supervisor. (P13 IMG)

It was perceived that a more personalised and tailored approach to supervision during induction would better support trainees.

> I think that's why you have an ES [educational supervisor], to tailor it to the trainee, although that's not always the case. My ES is really good, and even though she's really good, she's British born so she'll just say, 'Oh, just do this!' And I'm like, 'Doing this isn't very obvious to me. By writing a script for the placement planning meeting, it makes it easy for British trainees and I don't think it would inconvenience them particularly, but it would help those that aren't British massively. I suppose that's the kind of solution you're looking for. (P11 IMG)

Provision of information to improve

Some study participants perceived a lack of information from their ES on how to improve ARCP outcomes and progress.

> It's hard to show progress when I'm not doing anything different. I'm still seeing my patients, writing my reflections etc. So, this was my question: How am I going to show progress? And I don't think I've had an answer so far. (P19 IMG)

Missed opportunities/failure to support

Others felt there were missed opportunities to support learning, with some ESs perceived as '*too busy*' to properly oversee students' progress.

> I felt supervisors were too busy to read my entries in time so I could learn from them properly and too busy to oversee my progress and identify what I needed; it's maybe about giving the educational supervisors in GP surgeries more protected time; for the CEP it would be a lot better if we had protected time, the greatest learning is on the day. (P18 IMG)

Sometimes assessments were not signed off or missed by the ES.

> We had a discussion, but the discussion wasn't recorded. It was just in my reflection., but then it's up to him to sign the ticket and he (CS) never did. (P3 IMG)

On other occasions both trainee and ES missed assessments.

> Well, I received an outcome three because we missed the educational supervisor report, and we didn't do it in time . . . . But what was correct, and where I take responsibility and my supervisor as well, was that we did miss CbDs and COTs because I'd looked at the total number, and we did miss the ESR too. (P18 IMG)

Theme 2 perceptions of how WPBA reflects trainee performance

Validity, reliability and consistency

Many interviewees felt that WPBA was too subjective and could be improved with multiple assessors and greater clarity around grades.

> If you look at CbDs or COTs only, if you get those done just by one ES, it's not ideal because then it's quite subjective in terms of what the ES comments on. If they (ES) comment saying you're competent, you just meet the expectations or you're below expectations, if it's just from one supervisor the whole year, it's very subjective, isn't it? What I found most is that when other GP partners who were supervisors rotated, they gave me so much feedback indicating what was good or what I needed to work on. I felt you got more input. (P18 IMG)

> A trainer gave me "competent" or "meets expectations". He then attended a course, since then what used to be deemed competent, is now below expectations. The trainer changed their mind in a matter of a month. The new descriptions are unreliable, or the previous ones were unreliable. (P14 IMG)

Fairness, trust and transparency

Many study participants, whether UK graduates or IMGs, had concerns about the fairness of WPBA and questioned ARCP panel decisions and appeals.

> My supervisor sat in one of the ARCP panels for other GP trainees. Her comment was that some other trainees had exactly the same COTs as I did (same number, same type etc.) and the panel passed them. So, she

said that their comment was nit-picking. I didn't think it was fair. (P16 UKG)

You're asking people to re-judge their own decision that they've already made, so they'll obviously say, "Yeah, we agree with ourselves". It doesn't go to a separate panel, which would be fairer (P15 UKG)

Lack of clarity around the new Trainee Portfolio was confusing and demotivating for some trainees.

I find it so difficult to … I think it's mainly about putting things into my e-portfolio. I find the e-portfolio very confusing. I don't have any motivation. I don't know why I'm doing it and I find the whole layout very confusing. I don't know what they want from me., the new FourteenFish platform is worse than the previous platform. I found the previous platform (i.e. the old RCGP WPBA) much easier. (P4 UKG)

Individual assessments conducted in real time, demonstrating trainees' skills first-hand, were perceived as fairer than report-based assessments (e.g. the CSR) which was felt to be based on personal views of an assessor.

When it comes to the individual assessors, their assessments are fair because they're in real time, they're in real life and they see my performance in real life. So, the individual assessors are fair, but the extra requirements that the ARCP panel had listed on the report from the ARCP I didn't think were fair … Based on words you've written for the WPBA and words your educational supervisor has written, and then it all comes down to trust, doesn't it? Because they haven't seen your work. (P2 IMG)

Discrimination

Discrimination based on protected characteristics such as race, gender, age, disability, or sexual orientation, rather than competence, was perceived to operate during training and in WPBA by some study participants.

I'd say discrimination is the usual practice when it comes to all IMGs. If an IMG doesn't encounter it, then they are lucky. But this is the usual practice, so much so that it's considered the norm that they'll be belittled. (P10 IMG)

You could be the best doctor, but you just don't look right, and you don't fit into their picture of what a doctor looks like, so you don't win their vote. I've had a lot of issues because I tend to like the same clothes, so because of that and because I don't care very much about my appearance – I'll comb it quickly and put it back, and I don't wear makeup and things like that – I do look a bit dishevelled when I get into work and that's a long-term thing. So, I just decided to start wearing scrubs. I bought scrubs all in the same colour and I don't have to explain. People know who I am by what I'm wearing, and I don't have to think about what I'm wearing. (P4 UKG)

Study participants with a neurodivergent condition described how their disability affected their experience of WPBA.

Especially with regard to my disability (dyslexia, dyspraxia and features of ADHD), because they can't judge you if you don't have the full support required to be able to function like others. I think this affected my outcome. (P17 IMG)

Microaggressions caused offence and negatively affected self-confidence in one study participant.

If someone mentioned to me that they'd experienced microaggressions in their work, I'd be sympathising with them. It's only when you're in a position where you see these things yourself that you know exactly how it feels when it's affecting your self-confidence and so on. (P7 IMG)

Identifying challenges with specific WPBAs

There were challenges reported with specific elements of different WPBAs.

Another thing that's part of GP training are CEPS; Because as a GP [in] training, you're dictated by luck in that you do not decide who walks through the door. So, unless someone with a breast problem walks through the door, only then can you do a breast exam. (P1 IMG)

CbDs in hospitals can be quite challenging because it's hard to find the time to discuss them with supervisors. MiniCEXs can be quite dependent on the patient as well because the patient can have very difficult clinical findings or they can have a complicated history, especially if they're in hospital as well. (P3 IMG)

I think the reason why I got an outcome three is because I was looking at the total number of COTs I needed over the whole three years of training and I thought I had enough. But you need seven in the last year, even if you've done more in ST2 or ST1. I hadn't realised that which was my mistake. Obviously, I wish my educational supervisor had known more to be able to guide me in the right direction and say, 'We can't look at the total number; we have to look at each year separately. (P18 IMG)

The Trainee Portfolio (FourteenFish) was described as an excellent tool for self-improvement despite reported problems with structure and navigation of the tool.

Yeah, certainly. The strengths I can think of are that it's an excellent tool for self-improvement. I would agree 100% with that. It helps you to grow as a clinician in a positive direction. (P13 IMG)

I think it's the layout. I think with the new digital FourteenFish platform, there's just too much going on

> and too many colours on the screen. It's just too much going on and very difficult to navigate. I don't find it logical. The interface itself and the words project in a way that's overstimulating and that creates a lot of anxiety, which, in effect, just makes you not want to do it. (P4 UKG)

Study participants criticised changes to the system of WPBA.

> I think in the report, one of the comments on the report was that they'll reassess my WPBA according to the requirements of the time. I really strongly believe that if any changes are to be made for training requirements, it really should apply to the new batch of trainees rather than everybody having to adjust because it really is a waste of time. I've done more than three quality improvement projects and none of them counted. The time and effort put into these things is not small, and the number of times the college has changed their requirements is far too frequent. (P16 UKG)

Theme 3 communication difficulties affecting WPBA

Cultural sensitivity

Study participants who were IMGs expressed difficulties because of inexperience of the UK from early education through to NHS training and assessment programmes, and the new clinical knowledge required for this setting.

> I am an international medical graduate, so I don't know how much of it is down to cultural barriers. But there are more and more of us, so you might need to cater for us' . . . But the words are so vague, you feel like you need to change the world to be able to put it (write reflections) down. And I think there's a real lack of understanding as to what it (reflections) should look like and what's valid and what's not. So, I think we're disadvantaged on words like leadership etc. as it's a concept that's maybe more ingrained in British culture but not in other countries. (P11 IMG)

Language barriers

Language was a barrier to training for some interviewees.

> But for people like me, English is my second language, and although I was trained in the UK in English, sometimes I think in Chinese and then translate it. It takes me about an hour to two hours or sometimes a few days to structure a reflection to ensure it makes sense. (P16 UKG)

Reflection

One aspect of communication which was difficult for some study participants, whether UK graduates or IMGs, was the process of reflection.

> I am not a reflective learner: 'It wasn't for me fundamentally, that kind of reflection. But, again, it doesn't really suit my learning and writing style very much (P20 UKG)

> Yeah, the reflective part was very challenging because I really couldn't find the words or understand what they were expecting me to describe. (P6 IMG)

Theme 4 relationships, educational setting and their effect on WPBA

Relationship with supervisors, deanery, peers and patients

Interviewees reported the benefits of multiple supervisors, in supportive and compassionate settings, with time and space to connect with peers and supervisors. This was perceived to improve relationships that affected training, supervision and progress in assessments.

> ARCP, specifically recommended having two separate supervisors: one clinical and one educational. Exposure to different trainers to get to know their angle of seeing things helped me to grow. (P6 IMG)

Experiences of assessment varied with different educator support and teaching style, with negative effects associated with changing supervisors.

> My experience with supervisors is that they are extremely mixed in the level of support and prompting they give you. I've had two hands-off supervisors and I've struggled with both – I've had two hands-on supervisors who've been very attentive and understanding with regard to my portfolio, and I've found that little bit of extra support from the more attentive portfolio supervisors extremely useful. (P20 UKG)

Patients often provided positive support to GP trainees during assessments.

> I would say patients are more welcoming to the trainees. They want you to succeed and be their GP one day. And then they tell you openly about the challenges in terms of when you become a GP and then what to do. They tell you not to change. I think that screen is not there. They want you to be a better GP when you become a GP, so that's nice. I have done well in patient satisfaction questionnaires. (P6 IMG)

Effect of setting on experiences of WPBAs

Study participants often perceived assessments during hospital rotations as less relevant for GP training and facilities were often unavailable for trainees to complete WPBAs during shifts.

> I don't find it relevant at all. I think, in principle, I understand why it's supposed to be relevant, to get the exposure, but practically, with the day-to-day way

> that the NHS is currently, it doesn't translate to an effective use of my training, training time or skillset even remotely because you're just doing service provision. (P12 IMG)

> I think that in hospital rotations, we are really just purely providing services because hospital medicine is completely different from primary care medicine. I didn't even know anything about things like contraception, menopause – very basic GP things. I didn't even know any of that until I got to general practice, and I think that's very bad in terms of the training programme because those are the bread-and-butter things. (P16 UKG)

The quality of clinical and educational supervisors was felt to be very variable, which also affected WPBA.

> In hospital posts, GP trainees don't get time dedicated to do their portfolio. So, if they want to engage in their portfolio activity, it has to be done in their own personal free time, and its usually uncompensated work, which is unfair and makes it very challenging. Secondly, the quality of clinical supervisors and educational supervisors is a spectrum, and it needs to be more unified in hospital posts. (P1 IMG)

The quality of training varied depending on the placement.

> In my current placement, they've changed my practice about four times, and they've changed my deanery about four times as well. So, I'd say it depends on the deanery and the practice. (P2 IMG)

> It's a difficult one because it really depends on the practice. Like I say, if the practice has a lot of partners who are all positive about training, then it'll be fine. But when it's a practice where there aren't very many partners around, or they've assessed you and you've sent them a ticket, but they don't fill it in, then that's difficult. (P16 UKG)

Theme 5 effect on wellbeing

Challenges completing the WPBA negatively affected the psychological wellbeing of some GP study participants, causing symptoms of anxiety, depression, stress, burnout, lack of motivation, low self-confidence and morale, with some feeling seriously disadvantaged.

Feelings of stress

Some study participants described increased levels of anxiety, depression and stress arising from training that affected their performance and self-confidence.

> I had a problem with organisation and management. I was struggling with my time management. I was stressed. I had a difficult time during the training with depression and anxiety, and I wasn't able to finish in time. I was stressed all the time and I was worried they'd take me out of the programme. I'd lost my self-confidence and felt I wasn't as good as other people . . . . . I know there's no ideal system, but to have a better one would be good because what's happening now is I see a lot of burnt-out trainees. We had one trainee commit suicide recently, so it's a stressful job. (P17 IMG)

Low morale

Others described low morale and the stress of unsociable working hours during training.

> In the hospital, you don't really have much time to be a GP trainee and you don't really learn much in hospital to be a GP trainee because, obviously, it's a different setting, because it's really the morale that plummets because you feel like you're not learning anything. You feel like you're just doing ward stuff. It's okay for the hospital trainees because they know that they're getting something out of it. (P3 IMG)

Personal factors outside work affecting performance

Domestic strain could negatively affect study participant performance.

> The other aspect is there have been strains in the family, to the point where I had to have some counselling. I was told that, the things that I was facing at home would be classified as emotional abuse. So, I think that's another stress on top of everything else. I remember trying to study; there'd still be weekly stress and strain and shouting at home. So, I think that isn't the best situation for anyone to study for exams in. (P16 UKG)

Being sensitive to each individual trainee's needs was felt to be important.

> I feel that it's very depersonalised as well. I felt they (CS) were judging me in some way because they didn't even ask me why I was struggling or ask me about my situation. There wasn't even that kind of conversation. He just said, "Everybody's in the same situation. There's no excuse for you not to study for exams". So, I felt very upset by that because, at the time, my husband had to go into work and there was a lot of strain on the family. It just wasn't helpful. So, that's another piece of feedback I received. (P16 UKG)

Discussion

Main findings

We identified five themes describing participants' challenges completing WPBAs together with the reasons for these, effects on trainees and scope for mitigation: 1. 'Potential for early intervention', included personalised support and information perceived as important to support initial learning, promptly

resolve training difficulties, and achieve positive ARCP outcomes. 2. 'Perceptions of how WPBA reflected trainee performance' included perceptions of validity and reliability of WPBA and need for fair, trustworthy and transparent processes to reduce the risk of unfair discrimination. 3. 'Communication difficulties' were seen as problematic in relation to culture, language and reflection for some participants. 4. 'Relationships with peers and educational setting' were felt to affect performance. 5. Some participants experienced 'negative effects on wellbeing'.

Comparison with existing literature

Competency-based medical education should allow for flexible and individualised learning paths, due to differences in learners and workplace contexts [31]. Direct support from educators, online information and advice through deaneries is available to trainees [1], and information to access these resources, felt by some study participants to be unclear, has since been updated.

RCGP speciality training guidance, in place when the study was conducted, aims to make clear what WPBA requirements are. Changes to WPBA, which were confusing for some participants, are communicated through deaneries, the trainee portfolio and RCGP website, while educational supervisors are updated through email and continued professional development. Communications have been refined and clarified since the study was conducted [1]. Self-directed learning (time is included as part of trainees' contracts) if effectively used [1] should allow trainees to complete portfolio requirements.

Our findings suggest that assessments require monitoring to ensure fairness, particularly for IMGs and trainees with disabilities. A recent questionnaire study of GP trainees' and trainers' views of WPBA [4] found varying perceptions of fairness of WPBA, with most responding that WPBA was fair, but a minority expressing that WPBA had potential for bias and subjectivity from both assessors and patients. A previous scoping review of studies of bias in observed medical education assessments found that clinical examinations were more often biased in favour of women (15 of 19 studies), whereas race and ethnicity bias consistently favoured White students [32].

Enhancing assessor consistency through training may help them recognise their own subjectivity when judging performance, potentially prompting behaviours that support fairer marking [18]. Participants felt that learners should receive more training in how the assessment system worked, how assessment data were used, and how fairness was assured and monitored. To ensure fairness in the ARCP process, it is quality managed both at deanery level but also through the RCGP with external advisors [7].

Our findings highlighted that a clearer system to support IMGs to integrate into the UK speciality training programme was needed and since this study was conducted more support has been put in place. For example, IMGs are offered enhanced induction including up to 2 weeks working supernumerary at the start of training if they had never worked in the UK [33].

The ARCP, a formal process which follows the national 'Gold Guide', provides feedback to learners and is designed to be educational, supporting trainees to successfully complete training [7]. Although interviewees felt they lacked empowerment to appeal ARCP outcomes, the Gold Guide guidance supports trainees to request review of ARCP outcomes and sets out a clear appeals process [7].

Trainees are given the opportunity to write a reflective log entry on feedback received, and formative assessment offers opportunities for feedback which has been shown to have a major influence on learning [9]. Learning from assessment is enhanced when trainees reveal their thinking and are open to critique, which requires a relationship of trust with assessors [34]. Some participants lacked trust in their ESR, which informed their ARCP outcome. Understanding how trust develops and can be enhanced may allow WPBA to improve learning experiences and support assessment decisions [21,34].

Our findings showed that it was perceived as important to promote trusting relationships between educational supervisors and trainees [19]. Threats to establishing such trust were identified by some interviewees in this study, including inconsistency between feedback and grades, potential for assessor bias, and competing demands for educational supervisor time [19]. Employing strategies to help address bias [32] and provide educators with sufficient time and resources to employ best practice in assessment may also support trust.

The training setting, which is overseen by employers and deaneries, was deemed important to ensure a high-quality clinical learning environment, providing good organisation, study space and equipment, reasonable work conditions and hours, and adequate time and support for reflection and assessment [35].

The challenge of completing WPBA negatively affected some participants' wellbeing. Burnout is common in medical training and has numerous deleterious effects [36]. Our findings increase awareness of these psychological impacts [37] and offer further evidence for local pastoral support schemes [38], which are being provided and signposted [39].

Strengths and limitations

The study benefitted from a purposive UK-wide sample of GP trainees of varying gender, ethnicity and place of primary medical qualification, who had experienced difficulties with WPBA and ARCP at different stages of training. Interviews were conducted by non-medical experts in qualitative methods, but the interview schedule and analysis benefitted from experts in postgraduate medical training and assessment. The study took place in the UK and reflects the UK General Practice setting and WPBA rather than other countries and specialities.

An important limitation is that the analysis and recommendations are based on the experiences and perceptions of 20 study participants, only four of whom were UK graduates, all of whom may have started training or received an Outcome 2 or 3, before current supports were in place. Participants had not met ARCP requirements and may have been more critical of the system.

Implications for stakeholders and policymakers

This study provides information to guide policymakers, educators and trainees when considering improvements to clinical assessments. Although WPBA is designed, set and evaluated by the RCGP, it is undertaken by educators under Educational Deaneries. We hope our fundings will help direct changes to support further improvements in WPBA locally.

Formative feedback was considered important and how feedback is practised in clinical training situations is key for learning [40]. GP trainees need to be motivated to seek accurate, relevant feedback which is broadly consistent with their perceptions of their own ability to improve their performance [41]. The concept of Performance Relevant Information (PRI) has been proposed, providing feedback information relevant to the learner, drawn from workplace learning and interpretation of performance, arising from evaluation of patient outcomes after treatment: this includes observations of role model performance, incorporation of evaluations and assessments, exploration of feelings of failure or success and responses of colleagues and peers [40].

Various measures suggested to reduce differential attainment include advocating for diversity and inclusion at work, explaining information on differential attainment with learners, early identification of trainees who may require support, sharing information on adverse trainee circumstances with trainers, providing access to a range of mentors, training educators on differential attainment and the need for supportive enabling peer networks, ensuring protected learning time and sharing data [42].

As WPBA develops, the coproduction of assessment systems by educators and trainees, as currently exists in the design of WPBA, through educator, trainee and lay representation on the WPBA core group, may help to ensure that future changes are acceptable and feasible [43].

Conclusion

This study has suggested ways to improve WPBA specifically for trainees receiving an Outcome 2 or 3 at ARCP. It is important that trainees feed back their experiences so that training can be reviewed and developed. Although many suggested interventions and changes are already in place, it is important to continuously review the assessments, processes and supporting documentation to ensure they is fair, valid and fit for purpose, in preparing the next generation of GPs.

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Author contributions

CRediT: **Julie Pattinson:** Formal analysis, Investigation, Writing – original draft, Writing – review & editing; **Joseph Akanuwe:** Conceptualization, Formal analysis, Investigation, Project administration, Writing – review & editing; **Sureyya Sonmez Efe:** Formal analysis, Investigation, Writing – review & editing; **Kim Emerson:** Data curation, Formal analysis, Supervision, Writing – review & editing; **Bryony Sales:** Formal analysis, Writing – review & editing; **Shahid Merali:** Formal analysis, Writing – review & editing; **Andrew Wright:** Formal analysis, Writing – review & editing; **Attiya Khan:** Formal analysis, Writing – review & editing; **Aloysius Niroshan Siriwardena:** Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing.

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Ethical approval

The study was approved by the University of Lincoln Research Ethics Committee and all research was undertaken in accordance with the University of Lincoln Code of Practice for Research.

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