RCGP Workplace based assessment (WPBA) Core Group Position Statement on learning log entries and validation of log entries in GP Specialty training (GPST) WPBA portfolios.

Background

This position paper has been formulated to give greater transparency and clarity for collection and review of evidence in the trainees' learning log and hopes to improve the performance in the ARCP quality management process moving towards congruent standards.
In recent months there have been a number of complaints and feedback to the RCGP that relate to the increasing assessment burden and in particular

1. The onus of responsibility for educational supervisors' reading and validating log entries.

2. This is of a particular concern if secondary care clinical supervisors have not reviewed the learning logs for trainees in ST1/ST2 posts in secondary care.

3. There is still some confusion regarding the responsibilities of the clinical and educational supervisors with respect to review of the GPST WPBA portfolio.

The quality of the clinical and educational supervisors report is used by the RCGP Quality Management and Training Standards Committee (QMTS) as a surrogate marker for the quality of the supervision process, assessed against published criteria. These quality markers from each annual review of competency progression (ARCP) round are fed back and circulated to deaneries and form part of the quality management and review process for Deaneries.

Workplace based assessment (WPBA) in licensing for GP Specialty training

Workplace based Assessment serves two functions.

1. An Assessment ***for*** learning – Formative assessment

2. An Assessment ***of*** learning – Summative assessment

Licensing for GP Specialty Training consists of a tripos of three components, the applied knowledge test (AKT); clinical skills assessment (CSA) and workplace based assessment. Whilst the AKT and CSA are high stakes summative assessments, WPBA has a mainly formative role, and the global judgments contained within contribute to the summative judgement by the ARCP panel. That judgement is dependent on high quality recorded judgments from the educational supervisors. Trainees are supervised by both a Clinical Supervisor, often from a different specialty, and an Educational Supervisor from General Practice throughout their three-year programme.
For GP Specialty training programmes, the clinical supervisor may be a secondary care clinician supervising the hospital post for ST1 or ST2. There may be occasions for integrated/innovative training posts or GP in ST2 where the clinical supervisor is a GP trainer in addition to the GP trainer overseeing the educational programme (acting as educational supervisor). Each completes regular reports on the trainee's development of competence in the WPBA.
The quality of the clinical and educational supervisors reports is used by the RCGP Quality Management and Training Standards Group (QMTS) as a surrogate marker for the quality of the supervision process, assessed against agreed criteria. These quality markers from each ARCP round are fed back to deaneries and form part of the quality management and review process for Deaneries.

The requirements for clinical and educational supervisors are clearly detailed in the Gold Guide (1).

> **Educational supervisor**
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> **4.22** An educational supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee's Educational Agreement.
>
> **Clinical supervisor**
>
> **4.23** Each trainee should have a named clinical supervisor for each placement. A clinical supervisor is a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement. Some training schemes appoint an Educational Supervisor for each placement. The roles of Clinical and Educational Supervisor may then be merged.

The WPBA portfolio relies upon the principles of portfolio learning. The quality of the learning portfolio is dependent upon the portfolio builder and the evidence chosen for sharing and assessment.

The portfolio serves two functions, the first as an archive housing the trainee's educational/learning portfolio, their logs and any required assessments; the second and arguably more powerful is analytical, providing both trainee and supervisor with a vehicle for assessing progress to developing competence and identifying learning needs with the opportunity for formative feedback.

This second analytic role provides the formative element using the evidence gathering tools as pedagogic (teaching and educational) devices enhancing assessment for learning.

In order to offer appropriate clinical supervision and oversee and comment on a trainee's clinical performance during a training placement the clinical supervisor should review key areas of the trainees learning portfolio as well as performing the required assessments before reaching their judgements of performance given evidence of variable use of assessment tools. The use and application of mandatory assessment tools in secondary care is variable (2), which may make it difficult for the clinical supervisor to develop an overview of performance.

During some years of GP Specialty training programmes, the clinical supervisor may be a secondary care clinician supervising the hospital post. There may be occasions for integrated/innovative training posts or GP in ST2 where the clinical supervisor is a GP trainer working in collaboration with another GP trainer as the educational supervisor. In the final stages of training usually ST3 when GP trainees work solely in primary care the roles of clinical and educational supervisor are usually combined.

The purpose of the learning log in GP WPBA portfolios.

The learning log is an additional evidence-gathering tool, providing a range of learning opportunities that may be recorded and reflected upon. The learning log provides additional "naturally occurring evidence" (NOE), which balances the portfolio allowing the trainee to capture educational opportunities that might otherwise be

missed using the conventional evidence gathering tools and assessments (COT, CBDs Mini CEX and DOPs). It also provides the trainee with the opportunity for greater spread of evidence across the curriculum and competency framework.

The depth of understanding might be demonstrated by the quality of reflection in the trainees' learning log entries. A lack of insight is an early and powerful marker of underperformance and appreciation of the trainee's insight can be very difficult to establish by reviewing the mandatory assessments alone. This is an educational supervisor responsibility and an important source informing the feedback for educational supervisors reviewing a trainee's portfolio prior to staged reviews.

The sufficiency of evidence.

In order for the supervisors to make a judgement of progression, there must be sufficient evidence within the portfolio. Feedback from deaneries at ARCP panels suggests the following.

- The number of learning log entries for a GPST in the WPBA portfolio averages one to two per working week in ST1/2; the actual number of entries will depend on the educational impact of their experience in the workplace.

- Learning log entries should be recorded contemporaneously and not clustered and loaded shortly before a staged review. This is partly because the ability to reflect, on which insight is dependent, cannot be properly developed in short bursts of infrequent effort but requires the trainee to develop a habit of routinely thinking about their work. Additionally, a continual process allows early detection of insight problems and thereby much earlier, more cost-effective and fairer interventions.

- Learning log entries should be of varied format, providing an appropriate balance reflecting the current post.

- The specialty training portfolio should align to the GMC requirements for revalidation with
    - evidence of reflection on complaints, critical events and "near misses" recorded as significant event analyses (SEA)
    - evidence of a completed closed loop audit cycle.

What makes a good learning log entry?

There are many examples of training and benchmarking material that have been developed available on the RCGP website members area, http://www.rcgp-curriculum.org.uk/eportfolio/learning_log_stimulus_material.aspx
This position statement outlines principles that will promote reflective learning demonstrated in the portfolio by good learning log entries.

These principles include:

- Curriculum coverage that is brief and concise, linked to learning outcomes appropriate to the post and stage of training, with more reflection than description
- Competence coverage that is justifiable from the evidence and suggested by the trainee to the trainer for the latter to validate.

- Demonstration of development of clinical performance
- Demonstration of progression in learning

Who should read and validate learning log entries in GP Specialty training WPBA portfolios?

Both clinical and educational supervisors can have access to the trainees' e-portfolio and learning log, providing the host deanery has assigned them to the roles on the e-portfolio. For each post a GPST can have up to five clinical supervisors all of whom might comment on learning log entries. Both Clinical and Educational Supervisors are encouraged to validate log entries.

The GMC (3) and Academy of Medical Royal Colleges (4) have detailed the requirements for implementation of workplace-based assessment, which includes the roles of clinical and educational supervision (detailed below).
It is a principle of WPBA that the authenticity of assessment is proportional to the number of assessments, assessment methods and of assessors)

Educational supervision must include regular feedback about how agreed learning targets are progressing and encourage the practice of reflection. It also means keeping a record of such interactions between trainer and trainee so that both parties can look back on how an individual has been progressing.

The inclusion of assessments of performance in the workplace, rather than relying on formal and infrequent high-stakes examinations alone, should foster an environment where assessment for learning (along with assessment of learning) is seen as normal.

However, it is absolutely essential, in the potentially high-risk environment of clinical practice, to be able to identify those in need of additional support at an early stage. The record of on-going progress is used by educational supervisors in compiling evidence-based reports on the
progress of a trainee and as evidence informing high stakes judgements on a trainee's future progression, as part of the annual review of competence progression (ARCP).

This duality of purpose in assessment – the need to help trainees learn and develop; and the need to provide evidence for judgements on their progression – needs to be understood by all parties. This document explains the need to balance the benefits of these two purposes. If trainers and trainees approach WPBA in an open and transparent manner, then a culture, which nurtures trainees, need not be deflected by the essential requirement to assure everyone, especially the public, that our doctors in training demonstrate appropriate levels of
competence for their stage of development.

Clinical supervisors (CS)

The Academy of Medical Royal Colleges document states that the clinical supervisor should review the trainee's evidence monthly and provide regular feedback to the educational supervisor on the evidence of progression. The Academy of Medical Royal Colleges document outlines generic principles for good practice in specialty training including GP but does not recognize the unique situation in the hospital component of GP Specialty Training Programmes, where clinical supervisors from secondary care specialties supervise GP Specialty Trainees and they may not be fully conversant with the curriculum statement relevant to that specialty. A

pragmatic way forward might be for trainees to highlight in their self assessments a sample of their log entries that they consider best demonstrates their competency progression making them available for review as a minimum prior to completing the clinical supervisors' report (CSR).

Educational supervisors (ES)

The educational supervisor acts as an umbrella overseeing the entire GPST programme, commenting on educational aspects of the training rather than clinical performance, which is the role of the clinical supervisor. Arrangements in ST3 vary between deaneries but for many in ST3 the GP trainer has a dual role as both clinical and educational supervisor during the GP placement.
In order to review the portfolio and complete the educational supervisor's report and reach a judgement on progress the ES will need to review the learning log and sample log entries. Deaneries should encourage the involvement of all clinical supervisors in ST1/2 in assessing clinical performance to inform the educational supervisor through discussions with Clinical Tutors and Directors of Medical Education in Trusts.

Commenting upon and validation of learning log entries.

The GMC /Academy of Medial Royal Colleges (AoMRC) guidance suggests that the purpose of WPBA is to provide formative feedback, identifying developmental needs aspiring to excellence.

> *The WPBA framework identifies areas for improvement that are based on supportable evidence. Everyone, even the most able, has areas in which they could still improve; in this way, WPBA can encourage an aspiration to excellence.*

Therefore in commenting upon learning log entries, supervisors should:

- Comment on strengths and weaknesses (formative feedback)
- Identify developmental/learning needs
- Comment on progression

Curriculum linkage – GPST trainees will link log entries to the GP curriculum headings; the clinical supervisor might confirm if the linkage is appropriate and correct. In order to do this the supervisor would require some understanding of the learning outcomes detailed in the relevant curriculum statement. This may be difficult for clinical supervisors with a background in secondary care, but can be encouraged through the development of short curricular learning outcomes for each secondary care post and supporting initiatives for training secondary care clinicians with input to GP specialty training programmes. This allows trainees and clinical supervisors to engage with the curriculum and the educational value added for the GP trainee from that post. It also allows greater transparency when assessing educational opportunities and the attainment of learning outcomes.

Competence linkage - The supervisor assigns and "tags" learning log entries to areas of the competency framework when log entries are validated. Since the CS report (CSR) now clusters the competencies in the domains of the RDMp model (5 and appendix 1 & 2) we would encourage the CS to use the RDMp model when validating log entries. The clustering of GP competencies is simple to understand and being generic, is applicable to all specialty programmes. A simple e-learning (e-L)

training module (http://www.rcgp-curriculum.org.uk/mrcgp/wpba/clinical_supervisors_report/csr_e-module.aspx.) has been developed for the clinical supervisor's report which explains this further and we believe will greatly improve the consistency of reporting

What does validation mean?

Validation of a learning log entry confirms that the evidence the trainee presents using the learning log is appropriate evidence of the learning described by the trainee in the tagged area of the competency framework. Validation by the supervisor links it to curriculum and competency framework domains that can be viewed by the educational supervisor and ARCP panel. It does not mean that the trainee has demonstrated competence or that the validating supervisor makes a judgement on competence for independent practice, nor that the supervisor is validating the veracity of the described event in every detail. The purpose of validation is simply to present evidence that can inform the judgements and assessments *of and for* learning. Therefore when a supervisor validates a learning log entry in the e-portfolio they confirm that the evidence presented is referenced and linked to the appropriate curriculum or competency domain. The supervisor is not making a judgement of performance.

The West Midlands Deanery (6) has developed a form of words that capture something of the function of validation in an understandable way which is reproduced here with their permission.

"Think of validation as a process of choosing some learning log entries to be put in a drawer and looked at later. When a judgement needs to be made about demonstration of a particular competence, and educational supervisor (and the trainee his/herself) needs data. This will come from a variety of places including COTs, CBDs, MSFs PSQs, but also from the learning log. SO if a learning log entry has demonstrated reflection that is relevant to one of the competency areas, this should be highlighted (by validating the entry against that particular area). The educational supervisor and the trainee will then know where to look for evidence on which to base a judgement about progress towards demonstration of that competence".

References

1. Gold Guide (MMC) 2010 http://www.mmc.nhs.uk/pdf/Gold%20Guide%202010%20Fourth%20Edition%20v08.pdf accessed December 2010

2. Abigail Sabey & Michael Harris (2011) Training in hospitals: what do GP specialist trainees think of workplace-based assessments? *Education for Primary Care* (2011) 22: 90–99 2011

3. GMC (2010) Workplace Based Assessment: A guide for implementation http://www.gmc-uk.org/education/postgraduate/work_based_assessment.asp accessed February 2011.

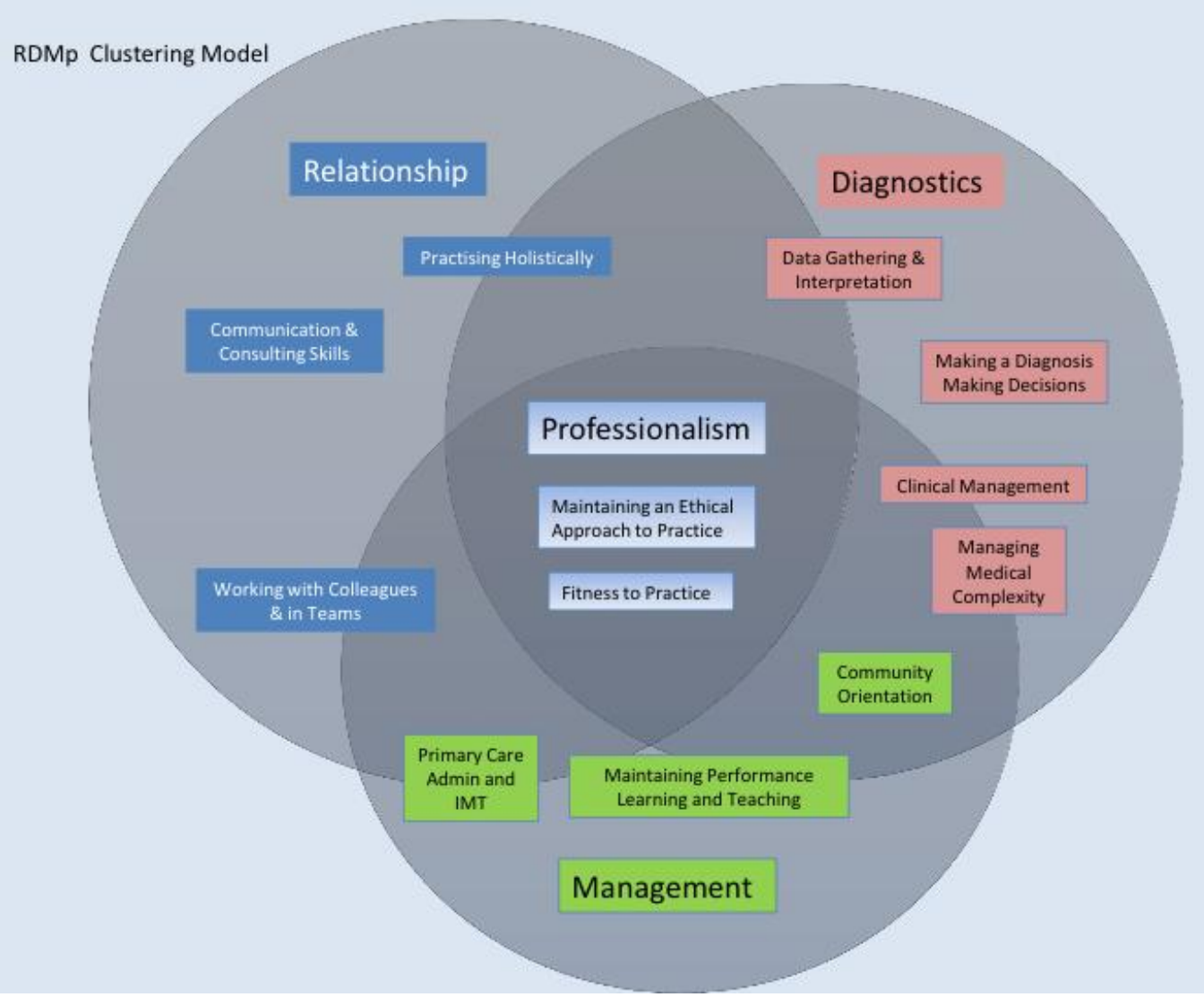
4. Academy of Medical Royal Colleges (London 2010) Workplace Based Assessment Forum Outcomes - 2010. http://www.aomrc.org.uk/publications/reports-guidance.html accessed April 2011

5. Tim Norfolk (2009*) A Unifying Theory of Clinical Practice Quality in Primary Care* 2009, 17 (1), pp37–49.

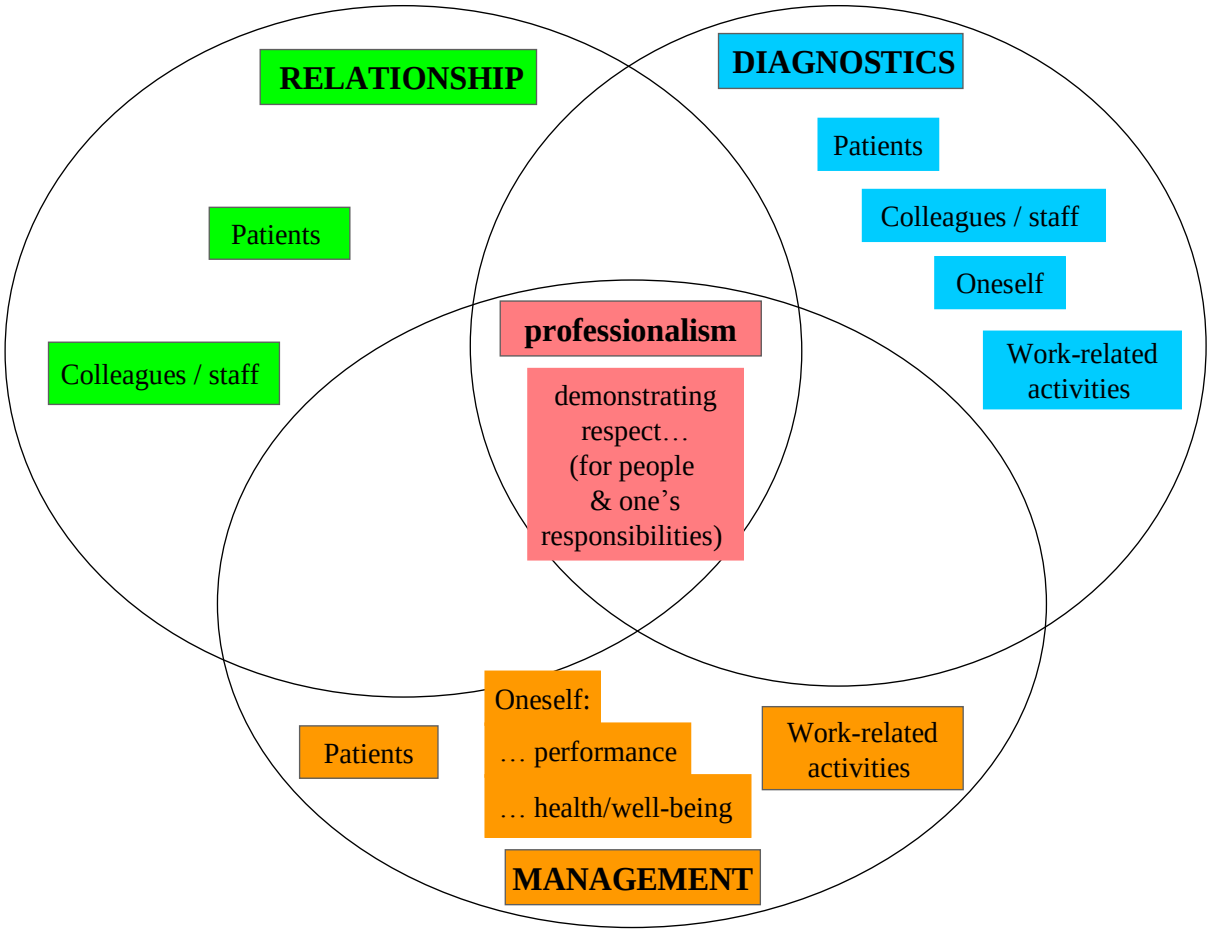
   Tim Norfolk & Niro Siriwardena (2009) A unifying theory of clinical practice: Relationship, Diagnostics, Management and professionalism (RDM-p) *Quality in Primary Care* 2009; 17:37–47

6. Personal communication: Mark Waters, West Midlands Deanery July 2011

Appendix 1: RDMp Clustering Model mapped to the areas of the competency framework.



Appendix 2: RDM-p: The Dynamics of Performance



THE MAP: SUMMARY

- Relationship. Relating with others in a professional context (whether patients or colleagues/staff), and will include: *Empathy, Communication skills, Negotiating skills, Leadership skills, Advocacy skills*
- Diagnostics. Gathering & managing information in search of optimal decision-making (whether with patients, colleagues/staff or oneself). A combination of knowledge and expertise, this will include: *Information gathering skills, Analytical skills, Decision-making skills, Technical & examination skills*
- Management. The wider handling of one's professional responsibilities. The challenge is to keep track of relevant issues over varied lengths of time, and will include managing: *Particular events* (e.g. structure/pacing of a consultation or home visit), *comprehensive/ongoing events* (e.g. maintaining adequate records, meeting wider responsibilities to community health), *relationships* (e.g. continuity of care for patients), and *oneself* (performance/learning/development and one's mental & physical health/well-being
- professionalism. Not a performance area in itself, but acting as the 'spine' running through the three performance areas (Relationship, Diagnostics & Management). Best defined as the level of 'respect' one demonstrates, at any given moment, towards the various aspects of the job. Thus a lack of sufficient respect (a) for others will weaken aspects of Relationship, (b) for 'due process' will weaken Diagnostics, or (c) for meeting one's ongoing responsibilities will weaken Management.

Quality in Primary Care 2009, 17 (1), pp37–49