

# A Critical Evaluation of the London GP Trainer Programme

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Table of abbreviations	Meaning
LGPTC	The London General Practitioner Trainer Course
PGCERT	Postgraduate Certificate of Education
HEE LaSE	Health Education England London and the South East
UCL	University College London
GP	General Practitioner
GMC	General Medical Council
CSA	Clinical Skills Assessment
AKT	Applied Knowledge Test

## 1. Executive summary

### 1.1 Background, aims and research questions

A new GP Trainer programme has been developed by Health Education England London and South East (HEE LaSE) in recognition of the need to expand GP Trainer capacity across London. It replaces a Postgraduate Certificate of Education (PGCERT) and there is a clear rationale behind the London General Practitioner Trainer Course (LGPTC): that the appropriate education of primary healthcare practitioners is dependent on trainers having a sound understanding of key adult learning principles, as well as the necessary practical and professional skills to facilitate effective teaching, learning and assessment in practice. The new course has purposefully lowered the barriers to participation by focusing on theory relevant to GP training, ensuring the practical application of theory to practice and ensuring that assessments of GP trainer's competence are appropriate. The course by these means aims to not only to encourage GPs to become trainers but in a very real sense ensure their preparation for practice.

The aim of this evaluation is to inform future developments in a multi-professional course for trainers by understanding what aspects of the course are working, for whom and why.

#### Research questions

1. What are the perceived **strengths and weaknesses** of the course?
2. To what extent does this course **effectively prepare** GPs to work as Educational Supervisors in primary care?
3. To what extent did the **online and pre-course elements** prepare participants for learning on the course days?
4. What aspects of the course could be further developed to **improve** its design, delivery and overall effectiveness?
5. Does the **course curricular** alignment support the development of key transferable skills?

Educational interventions are inherently complex to evaluate. Mindful of this complexity we have undertaken a realist evaluation inspired by a critical realist theoretical position. In keeping with realist evaluation research, we deploy a framework for this study in order to explore the critical active elements of the intervention. Reflecting the multifaceted and blended nature of the programme, we have conducted a qualitative study in which data obtained from analysis of course materials, participants reflective portfolios, observations of course days, and individual and group interviews with stakeholders and participants is synthesised. In doing so, this study develops a holistic understanding of the impact and effectiveness of the LGPTC.

The findings of this detailed and complex analysis inform our discussion of the implications of the course, as well as its suitability for preparing participants for both future training and further study.

### 1.2 Methodology

An exploration of the course materials was followed by a number of interviews and ethnographic observations. To access the perceived effectiveness of the LGPTC, as well as to understand how and for who it was effective, we interviewed 26 individuals (further information and demographics see Table 1) involved with LGPTC (either participants on it or stakeholder in it). To fully understand the

intended outcomes of the course we also conducted a documentary analysis of online and other course materials, which helped us to develop a number of 'programme theories' (see p10), that were then tested in our interviews. These were intended to supplement the learning aims and effectiveness that stakeholders revealed.

### 1.2.1 Participant sampling framework and recruitment

The study population comprised of a range of stakeholders and participants on the course. We recruited participants from Cohorts 1 and 2 of the course. All participants were initially approached to participate via email; email addresses were supplied by HEE LaSE. Focus group participants were first contacted via email and then recruited at a face to face taught day. All research participants volunteered to take part in the study.

### 1.2.3 Data analysis

A semi-structured interview schedule guided all stakeholder interviews and focus groups. The 'reflective' interviews were participant led, and were unstructured. All interviews were audio-recorded and subsequently transcribed verbatim by a professional stenographer. Observation data, interview transcripts and course materials were subjected to realist analysis. QSR NVivo 11© software was used to assist in the analysis and ensure inter-coder reliability. Data was analysed inductively from themes arising from the data but also deductively in response to the research questions and programme theories.

### 1.2.4 Ethics

Ethical approval was granted by UCL Research ethics committee (Ref: 13311/001). Participants gave written and verbal at the start of the interviews.

## 1.3 Results

1. What are the perceived strengths and weaknesses of the course?

- Strengths –the increased accessibility of the course, through a more realistic course duration facilitating GPs attendance and its practical focus were a real strength of the course. It was tailored and provided relevant theory which was explored on the face-to-face days. Small group work was also a key strength, tailored for participants learning needs and practice.
- Weaknesses - lack of formative assessment i.e. feedback on participants progress, lack of summative assessment and therefore formal accreditation, lack of content on GP registrar assessments (AKT and CSA). A lack of ongoing support from the LGPTC network was noted and maybe compounded by the limited impact of attendance of the GP Trainer workshops.

2. To what extent does this course effectively prepare GPs to work as Educational Supervisors in primary care?

On balance both stakeholders and participants feel that this course prepares them to work as educational supervisors in primary care: becoming GP trainers. There are some caveats to that and the lack of actual teaching experience being problematic arguably resulting in some participants not feeling confident. For some stakeholders the lack of theory may be problematic and undermine the effectiveness of new GP trainers particularly when they were dealing with unfamiliar or challenging situations, for example trainees in difficulty.

3. To what extent did the online and pre-course elements prepare participants for learning on the course days?

These elements were important and appeared to be relevant. The fact that they were discussed in the face-to-face days made them particularly useful. The “dry” and more academic texts appeared more challenging to engage with because they were sometimes difficult to understand and their real-world applicability was sometimes questioned. Some pre-course reading appeared to be off-putting - making participants less likely to explore the postgraduate certificate option.

4. What aspects of the course could be further developed to improve its design, delivery and overall effectiveness?

- Actual teaching experience would help GP trainers understand the role of theory and its applicability to real-world training situations. It may give them more confidence and may increase their feelings of preparedness practice. If actual experience is challenging to organise then proxy experience, through role-play in the small groups may partly fill this gap. Local trainers’ workshops and local networks could also be used to facilitate actual teaching experience but as participants noted a safe learning environment and trust were needed to be able to engage with simulated learning opportunities in a developmental manner.
- Developing assessments appropriate to becoming a GP trainer, which would provide course participants with more feedback about their progress on the course. Some form of summative assessment may make them feel that they have achieved a recognised standard and may provide more validity for external accreditors.
- Teaching on assessments - the course appeared to provide less information regarding the summative exams that GP registrars take. New GP trainers, understanding their future GP registrars’ anxiety around these high-stakes assessments, requested more information on how to support their learners better
- Ongoing support after the course would allow new trainers to consolidate their learning and seek help with real-world difficulties that often arise once GPs are in a formal training role.

5. Does the course curricular alignment support the development of key transferable skills?

The course supports the delivery of the key transferable skills outlined. However, consideration should be made as to whether these should be adapted in any way to better reflect those key skills felt to be important by stakeholders.

## 2. Introduction

### 2.1 About the programme

The London General Practitioner Trainer Course (LGPTC) was launched in November 2017 following revisions made across London and the South East to the path to becoming a general practitioner (GP) educator; which had previously involved having to complete a year-long Certificate in Postgraduate Education (PGCERT). The LGPTC's expressed purpose is to help meet the Department of Health 2020 targets for expanding the numbers of GPs working in primary care and increase training capacity in London. It's shorter length, and practical (rather than theoretical) focus was thought to be the best approach to efficiently preparing general practitioners to become GP Trainers. It was assumed that the learning that takes place on the LGPTC would be supplemented within GP trainer workshops that newly-accredited GP Trainers would attend, and by providing further professional development for GP educators to pursue *after* accreditation (e.g. a PGCERT). An aim of this evaluation is to determine to whether this structure and format is working, and what improvements can be made to it.

The course introduces participants to basic educational theory whilst also helping them to develop the *practical* skills believed to be necessary for becoming a trainer. Further to this, a number of 'key skills' are identified as being necessary to be a good educator, and the LGPTC seeks to develop these in participants. By the end of the course it is anticipated that participants will: be able to supervise learning in a one-to-one primary care context; be able to adapt to changing conditions and circumstances; be able to communicate information effectively; have developed a critical approach to learning; have awareness of basic adult educational theory; and have an ability to reflect on personal healthcare practice. An aim of this evaluation is to determine to what extent these learning objectives and key skills are met.

As part of the accreditation process in becoming a GP Trainer, practitioners are required to complete this new five-day programme. Crucially, however, there is no formal written assessment for this course. Instead, participants are expected to carry out the appropriate preparatory activities before each taught day and attend and participate in all course days. Should they wish to, participants are encouraged to produce a reflective portfolio of their learning related to the course, although this is not monitored. Once they have completed course tasks, participants are issued with a certificate of satisfactory completion of the course, and are eligible to progress onto the 'next steps' of the GP trainer pathway: formally applying to become a trainer. Part of our evaluation was to determine what impact, if any, this lack of assessment has had on the quality of trainers that have been produced as well as participants' engagement with the LGPTC.

#### 2.1.2 Course structure and content

The LGPTC comprises three main components:

1. Online and pre-course materials;
2. Face-to-face taught days;
3. Reflective portfolio.

Participants are expected to take a self-directed approach to their learning, alongside the formally taught components, and are responsible for completing a structured reflective portfolio. The content of the course is intended to be balanced between theory and practice, and participants are expected to engage with each component equally.

The course content is organised according to five themes:

1. Introduction to teaching and learning;
2. Day to day supervision and the curriculum;
3. Assessment and curriculum;
4. Educational Supervision: long-term supervision and progress;
5. Preparing for take-off: the trainee and trainer in real world.

Each theme comprises several learning objectives, along with suggestions as to how trainees might address these through relevant project work and reflection.

Participants are encouraged to complete a structured reflective portfolio which encompasses reflections on readings, e-learning materials, podcasts, skills practice and face-to-face days; as well as other items that participants perceive to be relevant to their development. The portfolio is not formally assessed but participants are advised that it will be useful in future applications to become a GP Trainer, as evidence that they are meeting the GMC standards for educators, and as evidence for their GP appraisal. Participants can also use their portfolio to apply for a HEE LaSE bursary for future academic courses – such as a postgraduate certificate, diploma or masters in clinical education. Bursaries are competitively awarded, and applicants are asked to submit a portfolio of their educational progress through the course in order to be considered for this.

## 2.2 About the report

*The report has a standalone, executive summary already detailed in chapter one. This section details the structure and overview of content in the remainder of the report.*

Chapter 3 comprises a brief outline of the theoretical and methodological approach used to critically evaluate the course. This chapter also includes a discussion of the limitations inherent in the design of this evaluation and ethical implications of the research. In Chapter 4 we present the findings of our research. Chapter 5 discusses the findings and notes their possible implications for the development of the GP trainer pathway.

### 3. Methodology

#### 3.1 Our approach to the study

Educational interventions are inherently complex to evaluate in part because they take place within, and are intended to act upon, complex socio-political systems from which they cannot be removed. There are many confounding factors that influence the uptake and success of a particular intervention, including its design and the context and environment that the intervention takes place in (Craig *et al.*, 2008; Wong *et al.*, 2012). Just as there are many confounding ways to measure its success; such as participants reactions and responses to training, observable trainee behavioural changes, and learning outcomes (Kirkpatrick, 1994; Kirkpatrick, 1996; Kraiger *et al.*, 1993). In recognition of this, and in adopting a critical realist theoretical position, we have developed a framework for this evaluation that incorporates key elements of understanding educational interventions (see Figure 1). This framework incorporates a focus on four theoretically constructed and inter-related core questions: what works, for whom, in what circumstances, and how (Pawson *et al.*, 2005; Pawson, 2013). We utilise this framework to explore the LGPTC, critically evaluating its design (i.e. how it's delivered and experienced), exploring why what works *does* work; and the actual (including unintended) outcome(s) of the intervention.

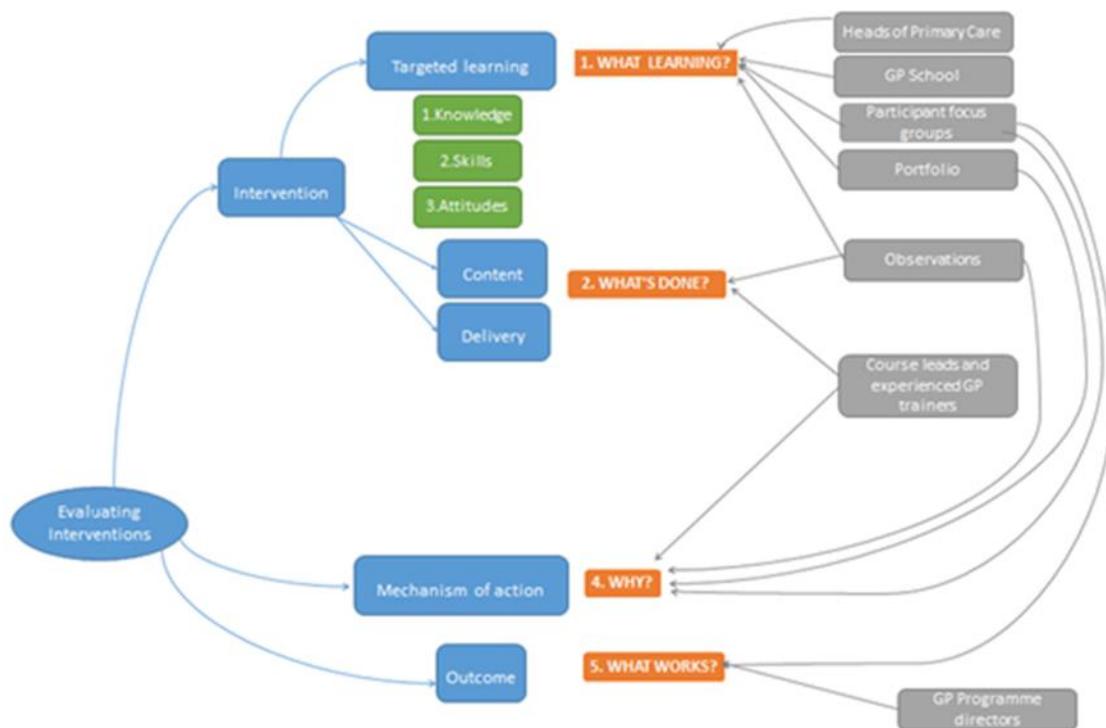


Figure 1: The evaluation framework for the LGPTC

The value of employing a critical realist evaluation is that this study provides *more than* an over-simplified 'yes/no' answer as to whether the LGPTC is effective or not. As well as offering this assessment, the true value of evaluating the LGPTC is to understand what about it does and doesn't work, and why this is the case. This is because doing so will provide information to help develop future effective trainer pathways. For this reason, it is invaluable to identify and understand the *causal relationships* between the phenomena that we capture – something that only a realist evaluation can provide. Indeed, this study offers a rich, detailed and highly practical understanding of this complex

intervention for GP educators. One that highlights how its component parts interrelate, interact, and lead to specific outcomes; insight which will be of much more use when planning and implementing further courses at national, regional and local levels. Following the precepts of critical realism, this study is concerned with formulating intersubjective conclusions relating to the value and effectiveness of the LGPTC in expanding GP Trainer capacity across London. As such, the focus of the research will be on exploring how participants subjectively understand and respond to the LGPTC. The application of critical realism here is valuable because this rationale permits (and necessitates) the researchers to delve deeply into the experiences of participants; asking pertinent questions relating to what components of the course led participants to make certain decisions or choose certain courses of action, and in what ways their circumstances also influenced such behaviours. This enables us to analyse the impact that the course did (or did not) have on such actions; but also highlights circumstantial factors that impact on learning, which can also be considered to improve the delivery of this and other courses. Furthermore, this emphasis on the formulation of intersubjective conclusions necessitates an inclusive focus when collecting empirical data, and places equal weight on understanding how stakeholders subjectively view and experience its effectiveness too.

This study produces a detailed and *evaluative* analysis of the LGPTC, founded in empirical evidence and related back to its intended outcomes, which focuses on highlighting the relationships between the context in which the LGPTC takes place, the mechanisms by which it works, and the outcomes that are produced. Thus, a detailed, comparative, and complex evaluation of the course is provided, enabling decision makers to reach a deeper understanding of the intervention and begin to understand how future training pathways can be made to work most effectively in various different contexts and for different types of learners.

### 3.1.1 Programme Theories and CMO Configurations

As has been noted, we critically evaluated the LGPTC using a theoretically informed approach; exploring why what works *does*, and highlighting the actual (including unintended) outcomes of the intervention. To do so, and in keeping with the realist approach to evaluation, we produced multiple 'C'-'M'-'O' configurations, which involved exploring the complex links between contexts (where, when and with whom the intervention takes place), mechanisms (how and in what ways the intervention takes place), and outcomes (intended and unintended consequences of the intervention) at play within the LGPTC. Doing so enabled us to consider how similar interventions may be affected by different contexts, leading to different outcomes, which was invaluable when considering the implications of the findings from this study. These C-M-O configurations were derived from all three forms of data collected (observations, documentary analysis and interviews); although the observations and documentary analysis were particularly useful in pinpointing various contexts (where, when, and who) and mechanisms (how), and the interviews in pinpointing mechanisms (how) and outcomes (consequences).

To create a comparative measure of effectiveness (i.e. to understand 'what worked') we made explicit the underlying assumptions about how the LGPTC was meant to work and what impact(s) it was intended to have. This information was found within the course literature, as well as by speaking with stakeholders who run the face-to-face days and design the course materials. These underlying assumptions constituted a number of 'programme theories' that we explored during data collection and tested during data analysis by looking for empirical evidence that supported, contradicted or modified these in some way. These programme theories were:

- Exposing course participants to educational theory will provide them with a ‘toolkit’ to use in practice;
- A course with a more practical focus will attract greater numbers of participants;
- A ‘light touch’ course with less formal assessment is more appealing to busy clinicians;
- A course with less formal assessment also reduces barriers and improves access to the trainer pathway;
- Assessment is not needed to drive learning;
- Creating local networks of trainers will motivate and support GPs to become trainers.

## 3.2 Research Questions

We were commissioned to address the following five research questions:

1. What are the perceived **strengths and weaknesses** of the course?
2. To what extent does this course **effectively prepare** GPs to work as Educational Supervisors in primary care?
3. To what extent did the **online and pre-course elements** prepare participants for learning on the course days?
4. What aspects of the course could be further developed to **improve** its design, delivery and overall effectiveness?
5. Does the **course curricular** alignment support the development of key transferable skills?

## 3.3 Data Collection

To collect data, this study triangulated three robust qualitative research methods: observations, interviews, and documentary analysis, each of which is discussed in more detail below.

### 3.3.1 Observations

Observation of the face to face taught days of the course allowed researchers to gain an insight into the ways in which the LGPTC team supported course participants’ learning. A total of two observations were conducted on days 4 and 5 of Cohort 2’s course. The observations also provided a means of recruiting participants for interview (1:1 and focus group).

The observations were used to collect data on a number of topics, such as: demographics (i.e. the time, place and people present); the topic for the session – this was particularly useful in understanding the afternoon sessions of the face to face days, for which there was no formal curriculum or detailed information provided; interactions between participants, facilitators, and tutors (i.e. how engaged all participants were, how effectively any relationships were being fostered between); and also the delivery of training and supervision – which was helpful in understanding how the curriculum of the LGPTC was applied in practice.

### 3.3.2 Interviews

The two focus groups were conducted face to face, along with one reflective interview. The remaining interviews were conducted via telephone. Semi-structured interview schedules (for interview schedules see Annex 1) allowed the research team to explore the lines of enquiry and concepts deemed important to the study, whilst still allowing sufficient flexibility to allow participants to share their views and experiences.

### 3.3.3 Documents

HEE LaSE provided the UCL research team with the LGPTC learning materials that were shared with course participants. They also shared 'tutor notes' that were detailed notes on the morning sessions used to let the afternoon tutors on the face to face days know what was covered. The UCL research team were also provided course feedback from both cohorts.

### 3.3.4 The study population

The study population comprised of participants from Cohorts 1 and 2 of the LGPTC, as well as stakeholders in the course. Stakeholders included those involved in the design and delivery of the course as well as senior GP leadership at HEE LaSE. The timing of the research, which was commissioned whilst the first cohort had finished their course and the second cohort were beginning theirs, meant that whilst interviews could be conducted with participants from both cohorts, observations could only be conducted with the second cohort. Furthermore, due to recruitment issues with cohort 1, there is a disproportionate number of participants from cohort 2.

### 3.3.5 Recruitment of participants

An email was sent to all tutors and participants from Cohorts 1 and 2, and all stakeholders in the course, via the LGPTC/HEE LaSE administrative team. This email explained the study and provided a participant information sheet. It also asked stakeholders and course participants from cohort 1 if they would like to opt in to an interview with a member of the UCL research team; course participants from cohort 2 were asked this at the face-to-face taught days that the research team attended.

Individuals who had consented to participate, took part in either a focus group or a one-to-one semi-structured interview. Interviews were conducted in this manner to encourage the sharing of unique experiences, but equally so they could be timed to best suit participants' availability. Interviews were conducted either in person or by telephone, according to the interviewees' preferences. Interviews were audio recorded for accuracy and transcribed professionally.

## 3.4 Data analysis

Interview transcripts were subjected to realist analysis. Due to how the data was going to be used to inform the research, course materials and observation notes were intuitively and deductively analysed. It was not necessary to conduct a stand-alone realist analysis of these materials as they formed part of the desk-based and supplementary research that form part of the overall realist analysis of the LGPTC. Specifically, they helped to construct the programme theories that informed the realist interviews, as well as highlight aspects of the context in which the course takes place.

### 3.4.1 Analysing observation data

Three members of the UCL research team (PC, MP, AM) attended two full face to face taught days; two members of the UCL research team (RV, LK) attended one face to face taught day. They observed and made hand written notes on both the morning and afternoon sessions, which were later transferred to electronic versions. After data collection, analysis was carried out wherein the data was organised according to common and recurring themes. This enabled findings to be compared against each other any patterns to be identified. This information was then used to inform the overall analysis of the course; an invaluable contribution of the observations was to enable the research team to better understand the context and mechanisms of learning on the face to face days that participants referred to in their interviews.

### 3.4.2 Analysing interview data

A coding scheme was developed inductively - with meaning flowing from the data - as well as deductively - to answer the questions posed by the research (Miles & Huberman, 2002). The principles of critical realist analysis guided the data analysis – thus an iterative approach, sensitised by theory, informed the categorisation and coding of the interview transcripts.

An initial coding scheme was developed by four team members (LK, AG, PC, MP) based on analysing four transcripts. Each of the four team members coded two transcripts each. The comparison between researchers' coding of the same transcripts (and discussion about these) was used to devise the coding framework. All of the research interviews were then distributed between, and coded by, three team members (LK, RV & AR) in accordance with the coding framework and using QSR NVIVO 11©. Once coding had been done, we re-convened to compare our analyses and carry out inter-coder reliability tests. Any remaining discrepancies were discussed until a resolution was agreed to arrive at a final version that we used as the basis for producing our results.

### 3.4.3 Analysing documents

Before data collection, course materials were reviewed and coded in a manner that helped to produce the programme theories that were developed and tested at interview. These documents were intuitively and deductively analysed during discussion with four team members (LK, AG, PC, MP).

## 3.5 Limitations

The potential limitations of the methodological approaches taken in this evaluation include concerns raised about qualitative research, which typically centre on the subjective nature of the enquiry. This evaluation mitigated against these concerns in a number of ways:

- It used a well-defined methodology and conceptualisation to shape the study design, data gathering, and data analysis;
- Three qualitative methods were used and triangulated;
- Throughout the analysis stage the research team met repeatedly and worked closely in ensuring the development of a shared understanding of the meaning of the data;
- A qualitative data analysis software package (NVivo 11) was used and inter-rater reliability of the initial analysis was assessed and clarified where necessary.

## 3.6 Ethics

The project was presented to the UCL Joint Research Office 13311/001 (Appendix 2) and given ethics clearance by Chair's Action. All participants were given the opportunity to opt in to, and out of the study, prior to this report being written. Participants volunteered to take part and actively consented, it was made clear that if they chose not to participate, it would involve no penalty or loss of benefits to which they were otherwise entitled. All materials were anonymised and are held confidentially in compliance with General Data Protection Registration 2018 (GDPR).

## 4. Results/Findings

In this section we present the main findings from the observations and the analysis of interviews with course participants and stakeholders. As a reminder, the role of documentary analysis was to inform fieldwork so there is not a stand-alone section here related to it. Instead, the findings from this are implicit within the programme theories listed in the previous chapter.

### 4.1 Observations

As has been previously noted, an invaluable contribution of the observations of LGPTC face-to-face taught days was to enable the research team to better understand the context and mechanisms related to the outcomes that participants referred to in their interviews. In addition to this, there were some interesting reoccurring themes found across researcher notes pertaining to the format of the LGPTC, as well as the teaching and learning that took place; which we share here.

#### 4.1.1 Format

##### **Morning sessions**

The format of the morning sessions was facilitator led, informal didactic style, which worked well. The link between the theory discussed and its practical implications was made clear; and this information was shared with participants in a manner that facilitated interaction with the ideas presented, and which enabled them to clarify points immediately. There was seemingly some flexibility in the sessions, with participant's questions being drawn upon to direct the whole group conversations. Observed sessions followed on logically from previous ones, but seemed to jump straight into the material – in the sense that there was very little introduction about what the aims and objectives of the session were or what the course participants were supposed to get from the day. In addition to the predominantly informal didactic style employed, there were some group tasks/pair work which participants engaged well with. During these individual 'break out' sessions and discussions, facilitators remained at the front of the room. Individual groups/pairs were then encouraged to feedback summaries of their work to the room – which was facilitated well.

##### **Afternoon sessions**

The afternoon sessions were less formal and less structured compared with the morning sessions; course tutors at times seem unsure on what has been covered earlier in the day and the afternoon content wasn't always perfectly aligned with it. Another contributory factor to this misalignment was that sessions were heavily participant-led; it is they, rather than the tutors, who appeared to determine the focus of the afternoon. A variety of formats were employed in the afternoon sessions, including whole group discussions, pair work, and role plays. Whilst most participants engaged with these formats, some appeared less engaged.

#### 4.1.2 Trainer learning and teaching

##### **Morning sessions**

Facilitators had developed a good rapport with participants. From the questions that were asked and interactions that were had, it was clear that a strong teacher/student relationship had been established between facilitators and course participants; participants treated facilitators as providers of answers – it is also worth noting that most questions here were practical and administrative queries (rather than theoretical). Participants seemed well-prepared for the sessions, but it was difficult to

judge how many had done the pre-course study as this was rarely explicitly referred to by facilitators or participants.

### Afternoon sessions

Course tutors had also developed a good rapport with participants, one which (much like the format) differed from the morning sessions as was much more informal in nature – in some groups it seemed as though the course tutor was as much a part of the peer group that had formed, as the group members themselves. There was a sense of comradery amongst learners. They have established strong peer networks based on afternoon group membership – for example, they communicate outside the course and collaboratively prepare for the afternoon session’s tasks. There is a sense that a very supportive learning environment had been established. Again, participants seemed well-prepared for the sessions, but it was difficult to judge how many had done the pre-course study as this was not referred to by facilitators or participants.

## 4.2 Interviews

Interviews were conducted with 26 participants. The breakdown participant demographics (relevant to the course) are detailed in Table 1. Interviews were conducted between May 2018 and September 2018, the average length of the interviews was 40 minutes but this ranged between 16 minutes to 63 minutes.

*Table 1: Participants roles and data source*

Total number of participants	Interview style	Cohort	Role
3	Reflective interviews	1 and 2	Course participants
2	Semi-structured	1 and 2	Course Tutors
3	Semi-structured	1 and 2	Associate Directors
4	Semi-structured	n/a	Senior GP Education Leads*
2	Semi-structured	n/a	Local Workshop Conveners
12	Focus groups	1 and 2	Course participants
<b>26</b>	-	-	-

\*Programme directors, Heads of GP Schools, Heads of Primary Care (merged to protect anonymity)

In addition to comments directly related to the course, a number of themes were identified through data analysis and also shape how we made sense of the information participants shared with us. These themes were: (i) The balance of theory & practical course content; (ii) The impact that assessment (or lack of) has; and (iii) Fitness for purpose and broader philosophical stance. Each of these themes are interwoven into a number of other relevant topics, but are drawn out in our analysis here so that we might make them explicit for our funders.

### 4.2.1 Course structure and format

The course’s practical focus and short time commitment are popular; and encourages high numbers of people to sign up:

*It's much more condensed and it's much more relevant than the course that I did <sup>1</sup>[Training To Teach [TTT]]. If I'm right in saying, they really do look at the things like the e-portfolio, so it's much more focused to what the trainer will be required to do, which I thought was really poor on my training. I think we had maybe a couple of hours looking at e-portfolio, but I didn't ever come away feeling that I understood what I was meant to be doing in that, within the portfolio. [Workshop Convener]*

*The new course there are people jumping to do it and queuing to do it because it's much more, as I understand it to be much more practical and less time-consuming. [Associate Director]*

*I had been really nervous about the level of work required for a PGCERT, and people often talk about how it's really theoretical, and it's a bit of a drag, and there's essay-writing. And people are quite down on it, generally. And so I was quite nervous about it. [...] So I was pleased not to be doing it, and [...] I think part of that is because, what was really nice about this course, and I think a lot of people felt it, it was really practical. You felt like they taught you the stuff that you needed to actually do the job, rather than the theory and then suddenly being thrown in the deep end and not knowing how you actually went about the day-to-day bit, being a trainer. [Course Participant]*

These characteristics make it more appealing to prospective trainers than the PGCERT, but also make the trainer-pathway more accessible to individuals that the PGCERT excluded. This is because of the less demanding and flexible approach to learning:

*The time [needed to complete the PGCERT] was difficult to take out of practice and personal time with families and things. And I suppose also on a personal note I'm really dyslexic and I can't write essays and it was all the essay writing [on the PGCERT]. Also, you know I can do the reading and I can do the learning but I just can't write fluently. [Associate Director]*

*...and I mean, certainly for one of the people, in terms of the fact that she's a mother with children, she found it much more accessible, because, you know, it didn't impinge on the family life quite so badly as well - Although in terms of face-to-face teaching time, I'm not sure the difference is that great really, but the, sort of, work you have to do around it [is helping] younger female doctors becoming trainers. [Associate Director]*

*You've got five days and hopefully you'll be good at training but for a lot of people it's a way of getting them access to this course because there's no way I could have done the old, you know, 20 days, out of the practice. It's essentially, it wasn't feasible for me to do that. [Course Participant]*

*So I thought I was going to have to do a PGCERT. Actually that was the main reason for putting it off [becoming a trainer], was that I thought even with all my CPD time, I would struggle to get that work done with everything else that was going on. [Course Participant]*

This less demanding and flexible approach is having no impact on the quality of trainer that is produced:

*I think the ADs probably didn't realise, not all of them realised the difference between people coming through...Yes, they don't seem to have spotted the difference between those who have*

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<sup>1</sup> Training To Teach (TTT) was the name of the previous GP Trainer course and was a PGCERT

*done postgraduate certificate and those coming through in anything they've said to me. Although, thinking about it, they seem to think- It's not that they didn't spot the difference, but they seemed to think that they have...they've certainly got the basics. [Senior GP Education Lead]*

For participants, the course has struck the correct balance between theory and practice; introducing educational theory without confusing or overloading them. Its format creates an adult learning environment which is valued by participants; especially the course facilitators' adapting of content to the needs of the learners:

*I like the way as well though, you're taught for the first part of the morning, entertained at the taught theory of it with a bit of a presentation and didactic slides, etc., but then towards the end of the morning you'd have that small group where we'd all break out a little bit and we'd have our own thoughts and then we'd represent them back. And it, kind of, put a bit of meat on the bones, really, of what was being said, so if you fully grasp it then that definitely, that was a really good aspect of the course. [Course Participant]*

*And there was a lot of flexibility in the afternoon session, like our facilitator used to say if you don't want to talk about the morning and if there's something else that you want to do, then sometimes we did something completely different in the afternoon, which was relevant to our group and which the group decided the week before. [Course Participant]*

However, it was clear that not all of the course participants completed the self-directed components:

*Well, most of my course didn't really do the self-directed...You know, in the small groups they were honest enough to say, listen... And I think there's one person who I think would have done it anyway, because she was really interested [in the] reading. I had a positive group, but a number of my group weren't doing that stuff. [Course Tutor]*

*Well, not that they would have said they'd done nothing, but yes, pretty sure there was someone who's done nothing, yes. [They were] quite a good blagger. [...] And I thought that everyone on the course would be quite excited about what they were doing, but I was surprised by how many people were really not excited about being there. And I couldn't really work out why they were there at all. What was driving them? They were doing a course in order to be trainers, but they didn't really seem to have any desire to. [Course Participant]*

Thus, an approach to course design and delivery that was designed to enhance accessibility and flexibility led to elements of the programme being ignored by some of the participants; and still faced issues with engaging participants with the content.

#### 4.2.1.1 Pre-course materials

Engagement with pre-course materials depends on the participants: a course tutor found that some participants engaged more than others, and this may have had to do with their role (whether they are a partner or not) or other commitments.

Course participants found the pre-course materials “manageable” and “relevant”, and when raised in the face-to-face sessions reported how they were able to consolidate their learning by ensuring understanding:

*It was manageable. And it was quite relevant as well, they weren't asking us to do something which wasn't then discussed again in the course. So, it wasn't something that if you have not understood it or you've not read then it's completely, like, a wasted resources, it was always, I think it was just, like, a bit of a taster and it was always elaborated in the course. [Course Participant]*

One participant described how the video and podcast materials were particularly useful, both because of their brevity and because they were more clearly designed for their learning needs:

*I think they [videos and podcasts] were slightly more user friendly, and you could focus a little bit more because they were, they were nice and short. There's... I think they were well done as well. They were clearly directed to us as that specific learner group. Whereas the articles, although there was definite relevance in a lot of them, the, I think they just weren't as directed to our learning needs perhaps. [Course Participant]*

A course tutor also thought that the podcasts were “easier” than the reading, and so participants seemed to engage more with these materials than the written.

A course tutor suggested that having tasks and materials more relevant to the participants' own experiences of being trainees might help with their perceived lack of engagement with pre-course materials. It is hard for them to engage with theory and discuss examples about trainees on the face-to-face days when they do not yet have trainees themselves. They are able to contribute more on the face-to-face days when they can talk about their actual experience:

*Some of the papers... I mean, like there was a very dry one on curriculum planning which you could... I think maybe if they'd chosen sort of things that were... or tried to think of tasks that were a bit more relevant to their actual work of being a GP trainer and their own experience of having been a trainee, it might have got a bit more buy in. [Course Tutor]*

A participant found that most of the pre-course reading was useful for the face-to-face sessions and seemed to map on well to the taught days; however, some lengthy articles were felt to be quite difficult and abstract. Having the associated teaching session beforehand, in which these articles were discussed, would have made them more accessible and useful as a consolidation of the face-to-face learning:

*So there was some - In the first couple of weeks, and I can't remember who [...], but there was a couple of articles which were quite long, quite abstract without having much discussion prior to them. So for some of them, I did think, oh, could we've had a discussion around this and then used it to consolidate? Now I know I've just said I did do pre-course reading. But these ones, I think - I think the reading always has got to be attached to what you've done that day. And I think it wasn't always completely joined up. It was, oh well, read this if you want rather than this is going to consolidate your learning from today. [Course Participant]*

#### 4.2.1.2 Face to face taught days

##### **Morning sessions**

Course participants felt that the facilitators created an engaging learning environment in the morning sessions, where participants could ask questions in what felt like an adaptable “two-way process”:

*Generally I think people felt quite engaged, you know, it was very much to and fro, it was a discussion, they would deviate from their plan if somebody asked something that was relevant.*

*So, it didn't feel like they were, sort of, going, you must learn all of these things, tick, tick, tick, it was quite an adult learning environment, it was conversational as well." [Course Participant]*

Course participants had a positive impression of the morning sessions, describing them as running "smoothly", with just the right amount of information conveyed, "enough to make you think you have enough to move forward, and then enough for you to take those discussions forward into the afternoon". One participant found one morning session not very useful, as they were sometimes repetitive; covering similar topics each time – an example provided was how one session included content on reflective writing that had already been covered in previous sessions and in pre-session reading.

### **Afternoon sessions**

A course tutor described how the course participants found practical tasks particularly useful in their afternoon sessions, such as looking at the portfolio, learning logs, and examples of these; as these are things that they will be working with once qualified as a trainer, the participants can see the relevance of doing this work in the course. The same tutor aimed to make their afternoon sessions participant-led, to ensure that the group's learning needs were identified and met, rather than imposing a structure on them. They did this by making sure they knew what was covered in the morning session, including the pre-session materials, and then asking if the group wanted to ask anything in relation to the morning's topic; in this way any misunderstandings could be cleared up swiftly.

Participants found the opportunities to do role-plays particularly engaging; they were felt to be challenging, and as such helped to consolidate the day's learning:

*Certainly I feel that the challenge really comes with things like roleplaying and, you know, that, sort of, gets the blood flowing, the adrenalin going [...] So, I think that's something that certainly I feel, sort of, challenges you but puts you on the spot and really ingrains some of those - Certainly shores up your learning for the day. [Course Participant]*

The format of the afternoon sessions, with a smaller group meeting every time with the same facilitator, was viewed positively by participants. The continuity of working with the same people for the duration of the course allowed a level of trust to develop, resulting in a safe space for participants to share their experiences and concerns:

*And some of the things were really personal that they wanted us to do, a personal CBD or a personal problem with a colleague, and I think it is only effectively done if it's a small group where you have the trust. [Course Participant]*

Having developed this trust, it enabled peer learning to take place; as the group got to know each other well they felt able to try out new learning or teaching styles, and receive and provide constructive critiques without feeling "judged":

*I think one of the benefits in the afternoon was that, because it was a smaller group in a separate room and there was an understanding that we would keep our discussions amongst ourselves, you felt very protected. And you felt that you could role play and try out new learning styles—learning or teaching technique is probably the right word—without the fear of being looked at by lots of people and judged. So you got to know your group. It was the same group throughout five weeks, and it did feel very comfortable that we could feed back to each other, critique to each other, question each other in a nice way, which definitely wouldn't have been possible in a large group. [Course Participant]*

Peer-to-peer feedback that is particularly well facilitated in the afternoon sessions of the face to face days:

*And we can give each other constructive feedback and we've been doing it long enough that we're not so nervous or scared by that, I think it's a much more effective way of learning rather than a lot of, kind of, lecture-based but even that said, I don't think the lectures have been too long or rambling on the whole. [Course Participant]*

One way in which the afternoon sessions could be improved would be to have more structure to them. This would allow more people in the group to contribute, and could provide space for more interactive exercises such as role-plays to take place; this would create more of a challenge for participants, which in turn would help to consolidate their learning:

*Yes, I think the group sessions could have been more structured so that everyone got a turn to be in one of the roles because in ours it seemed to flow a bit too much so some people got to speak a lot. Some people didn't get to speak at all. It's, like, one, two, three, four cases rather than being all eight people getting a chance to contribute. [Course Participant]*

Course tutors found that they had to be adaptable when course participants had not done the requested preparation for the sessions, and this meant that what was covered did not necessarily match up with what was in the course description. Possible reasons suggested by the facilitators for participants' lack of preparation included participants being busy and not realising the work involved in this course, or not realising the relevance of the various exercises or the preparatory theoretical reading.

Course tutors also found it challenging to balance covering a large topic in a limited time with addressing the group's learning needs; when new learning needs did arise, they did not necessarily have the time to address them, leading the tutors to worry they are "not teaching them what they need to know in this session". It was felt that in the previous format of the course there was more time to include recaps and discussions of difficulties in the afternoon sessions before moving on to the new topics.

One participant described how their group was not as engaged as they had expected, and so found the afternoon sessions less enjoyable and did not want to engage with their peers in the group. The learning environment is in part created by peers, and as "there was a lot of cynicism and negativity" this negatively affected the environment for this participant. The participant was very motivated to be on this course, but found their peers to be less so, possibly due to having other unclear reasons for attending:

*But it wasn't completely obvious to me why they were there, and then if they were, why they were so apathetic about it. I can't think what else it would be, apart from money, because I don't think it's particularly status. I think there's other things. I mean it has status for me, but from their attitude it didn't seem like it had status for them, so I don't know. [Course Participant]*

#### 4.2.1.3 Reflective Portfolio

Doing the reflective portfolio gave one participant the opportunity to critically appraise their current role and how they approach their teaching. This “head space” meant that they really benefitted from being able to reassess their teaching practice in this way:

*And it gave me a bit more of a framework in how to tackle different kinds of learners. Maybe I probably would've come to that anyway over time, but going on a structured course, taking time out away from the practice, afforded me just some head space to do that. Which, for me, I really felt very engaged with that, because that's probably the single biggest thing that was most useful for me; just the benefit of looking at how I approach teaching and education, and what can I do to be even more successful in the eyes of a student or a trainee? [Course Participant]*

When asked whether any of their group's participants had completed the reflective portfolio, a course tutor replied that they did not know; as the tutors were not asked to mark the portfolios, they could not know how many were completed. Their understanding was that the portfolio only really needed to be completed if participants wanted to apply to do a PGCERT; perhaps there is only the pressure to engage with this part of the course if participants want to engage further with their education in their area.

Participants spoke of how writing reflections can feel like a chore, just one of the many other tasks they need to complete for work. With limited time to devote to their own learning due to service delivery commitments, participants can feel unengaged with this component of the course:

*I think the majority of us are reflective and that's what, as a human being, we are. And that's how we carry on and for me, that's how I practise all the time. But doing it for somebody else to prove to them that actually I'm doing a safe job, that is the bit which I feel that sometimes that I have that compulsion with all the other things that we have to do, that we have to show somebody but with all the things now, there's no way around it so we just have to carry on. [Course Participant]*

Furthermore, having to write down reflections and share them to be assessed by others can feel “contrived”, where the reflection is done for others rather than yourself:

*Yes, there's a pay-off between your own internal reflection and providing a log of your reflection. And quite often the reflecting that I've done internally is the useful bit. Putting it down on paper seems like a bit of a chore sometimes. [Course Participant]*

Participants also described finding it difficult to reflect ‘on demand’, for example when given a handout on which to write some reflective notes. Some found it easier to reflect by discussion with peers or trainers. They were more able to fully engage in formal written reflection when given time to do so after the event:

*Participant A: Yes, I think I would prefer a reflecting in the chatting, you know, discussion, that, sort of, way and actually, when I have to write down reflections, I struggle a bit with writing down reflections.*

*Participant B: Particularly right then and there when you're given a piece of paper and, sort of, reflect. It's, kind of, like, my brain seizes up.*

*[omitted some intervening talk]*

*Participant A: Yes. I mean, you're not actually reflecting. You're just writing down a couple of things that acts as prompts for later when you are actually forced to reflect and hopefully by then you'll have thought of something to reflect upon.*

Completing the reflective portfolio is a key to accessing funding to move on to complete the PG certificate. When asked whether this was something being considered, one participant replied that they had intended to but were less likely to after attending the course. Some theoretical parts of the course were felt to be irrelevant to this participant's practice, which resulted in them feeling less engaged with theory in general:

*Because what I have found in myself is whilst I really do love teaching, what I don't really love is the theory of teaching. I find it, like - I mean, some models I think are useful and but some of it I find, like, not applicable for me, particularly. I mean, I might change my mind but at the moment that's how I feel. [Course Participant]*

However, the reflective portfolio was not just perceived as a task necessary for moving on to a further qualification; one participant wrote regular reflections after each contact day, but recorded them within their "normal GP portfolio" rather than in a separate place specifically for this course. Their reasoning for carrying out this reflection was more personal than for professional development, as they thought they "wanted to show it for [their] own creative self".

Participants expressed some confusion about the purpose of the reflective portfolio and how it should be carried out. Even if they intended to produce some written reflection from their time on the course, it might be for general professional development, rather than for this course in particular. As they are expected to reflect as part of their GP roles already, reflecting further from a different perspective may contribute to this confusion:

*Interviewer: So, some differences there on how people have engaged with that?*

*Participant: I think all of us have or do intend to write on the, like, something in some way or form, on the electronic portfolio.*

*Interviewer: So, that's, like, a professional portfolio, nothing to do with this course?*

*Participant: Yes, but if they meant anything different then none of us know.*

#### **4.2.2 Overall preparedness to train & the role of workshops and peer support**

Some participants felt prepared to train, and described the content of the course as giving them confidence in beginning their new role, and equipped them with useful educational skills such as the ability to give effective feedback:

*I came out thinking, great, I got all the information that I need just now...I did really feel ready, definitely. And I definitely didn't feel ready before...It felt like it was a big, a big achievement, and a lot of confidence came from it. [Course Participant]*

But others did not and, as we will come to discuss, felt that they could have been better prepared – particularly by giving the course an even more practical focus. Stakeholders felt that, while the early signs were encouraging, it was too early to judge the effectiveness of the training in the context of genuine educational practice:

*Have they done reasonable applications? Yes. Have they done a reasonable two or three-hour interview? Absolutely...but in reality, what's the quality of their training going to be like...It's probably too early to say. [Associate Director]*

When asked directly if the new trainers were as prepared as their predecessors for their role, one interviewee involved in assessing and accrediting trainers highlighted the importance of local GP trainer workshops as playing an important role in supporting workplace learning:

*I do think having the support of the workshop is absolutely vital...I'm certainly not approving anyone until...I want evidence that they're going regularly to the workshop because I think that is important. [Associate Director]*

However, discussions with workshop conveners suggest that the contribution of these regional workshops is not as great as planners and assessors might believe. It was noted that the workshops meet infrequently and are really only helpful to those that have a trainer – something that an LGPTC course participant would not have. Importantly, LGPTC alumni were either not known to workshop conveners or were known to be unable to contribute to discussions as they don't have a trainer yet. The overall sense was that workshops are not conducive to preparing trainers to train, but may be a support mechanism (providing they weren't placed into a 'cliquey' one) once accredited.

*A lot of our workshop has been discussing current trainees and issues that we currently have with trainees. And of course they're [LGPTC participants attending workshop] limited with where they are able to give any input because they're not actually with a trainer, trainee - They haven't got any personal experience yet [...] They don't really contribute [...] It's all about for them and about whether they feel comfortable with the group because ultimately as a trainer you need to feel comfortable within the workshop because you've got to be able to raise issues which may be quite sensitive and obviously personal. [Workshop Convener]*

Despite this, involvement in a local trainer's workshop was believed by a number of stakeholders to be important, in part due to the provision of mentors: *"I think that [workshop attendance] is quite important and a lot of workshops have been assigning mentors to them"* [Associate Director]. Indeed, all stakeholders saw the workshops as an important component of the trainer pathway; one that justified the shortening of the trainer course, and which supplemented the curriculum of the LGPTC. The importance of local trainer workshops was also highlighted by a course participant who was less confident about their readiness to train:

*The e-Portfolio I did was very different. So, in that sense, you know, how to fill this in, it does form a little bit of dread. The opposite is that, you know, there is a group I can turn to, the smaller groups that we've got as well as the workshops. [Course Participant]*

Interestingly, this participant seemed to suggest that the small groups that were created as part of the structure of the course for the purpose of facilitated group discussion activities, would remain as a source of support after the end of the course – something which we pick up on later in this chapter. Indeed, ongoing support was important to course participants, and another trainee saw the workshops as an important source of ongoing support beyond the end of the taught programme, the role of which was to highlight "areas that if you want to get some help with you can go to your trainer workshop and clarify things before you get your trainee".

The idea that learning would, or should continue beyond the end of the programme was voiced by a number of stakeholders too. A course tutor saw the programme as the start of a journey that would continue throughout the remainder of the trainer's career:

*I think it is very much the start of it, the start of the journey really...And then I think the next step for them after doing this would be to try and put it into practice. [Course Tutor]*

This tutor went on to say that learning beyond the end of the programme, in which new trainers are getting to grips with applying their learning in practice, should be formally supported via a further contact day:

*Course Tutor: Maybe at that point, that's when they need another... maybe after they had training for six months, they need to have, you know, actually did it work, what new needs did you identify, how do... maybe a little bit of ongoing support or something like that rather than making this bit of the course longer.*

*Interviewer: So you think a follow-up day about six months later...*

*Course Tutor: Yes, once you've had a trainee and are actually doing it.*

### 4.2.3 The balance of theoretical and practical knowledge

#### 4.2.3.1 Theoretical

As we noted earlier, the content of the LGPTC was much changed from the original PGCERT that it replaced, and stakeholders expressed a range of views about this. For some, the lack of educational theory was believed to be problematic. Describing the course as "theory-light" or even having "no theory", there was a fear that new trainers would not be adequately equipped for their role: "If you haven't got the theory behind you it makes it [training] more difficult" [Associate Director]. Others believed that a greater emphasis on theory might deter otherwise good trainers from taking the programme:

*And some people really aren't theory people. They really aren't essay people. So that did cut out a little, a group at point when that came to those aspects, I suppose. [Course Participant]*

*But, you know, there are some very, very good less-academic people teaching who I think stand a better chance with the new course and the PGCERT did put some of them off. [Associate Director]*

One course tutor felt that there was sufficient theory for now, but that it was very much a pump priming approach, with the hope that trainers would continue to learn more about education theory as they progressed through their career and applied theory to practice:

*I think they get an introduction into educational theory and the basics, but I think it is very much the start of it... I mean, I think it's knowing the theory exists, which they have varying experience of how much they know about it. It's understanding how it's put into practice. [Course Tutor]*

Indeed, stakeholders feel that knowledge of educational theory is important.

*I think you're much more likely to be a better educator if you've got a thorough understanding of educational theory. You know I think it's something that assist you in that developmental journey. [Senior GP Education Lead]*

*I do [think that educational theory is important] because I think what we're talking about is being educated and not trainers, and I think there's a common notion out there, GP trainers think, well, hold on when not educators. We are trainers. And I think that gets to the heart of it. And I think you need some basic adult education theory. [Senior GP Education Lead]*

Interestingly, one of the course participants perceived that there was **a lot of emphasis on theory**:

*And, I mean, think there's been quite a lot of emphasis, I thought, and sometimes on that theories of education and discussions around those, sorts of, things. [Course Participant]*

Thus, it seems that for some course participants even the greatly reduced theory content (which was acknowledged by the majority of stakeholders) comprised a greater proportion of the course than they would have liked. But also that this theoretical focus did not help them to feel prepared and confidence in their abilities to train:

*...actually what I'm worried about is how am I going to actually translate that into having somebody sat in a room with me and trying to be their supervisor [Course Participant]*

*I don't think that I feel super-confident based on just this course to then go ahead and be a trainer. [Course Participant]*

Some theory stuck though, and course participants who were very engaged with the course noted that their 'theoretical take-aways' included the trends in educational philosophy and theory (for example, socio-cultural approaches to teaching and learning); the shift from teacher to learner centred education; the shift away from didactic to heuristic teaching methods; and reflection. They felt that this theoretical 'tool box' meant that they were better prepared to supervise their trainee once assigned. One, debatably less engaged, participant describes how the theory stuck with them, too:

*Interviewer: Have you had to draw on anything yet from the course that you - ?*

*Course Participant: Yes, I actually, it's funny what - Because you think, oh yes, I just go through the motions. But I actually do - So we [IE and their trainee] did an observed consultation yesterday, which is the first one that [the trainee] had done. [...] And particularly the, through the advice, we're giving feedback—that was really helpful—about not being afraid to go into the uncomfortable space when you are doing the feedback as long as you stay objective and on topic. And I felt that I was able to give her good, and I don't mean positive, well-evidenced feedback, if you see what I mean, which - And thinking about myself prior to the course, I'm not sure I would've been able to do it quite so well and I may have just said 'oh yes, very well, well done' and picked out a couple of things. [...] And I felt that it was - Yes, I was able to give the evidence that it was a good learning experience for her.*

One stakeholder – an experienced trainer - felt that 'the real world', rather than a classroom-based course, was where much of the learning to become an effective GP trainer takes place. For them, the (perhaps sole) purpose of the trainer course is to introduce trainers to theory:

*I do think it's easier to learn on the job...I don't think that the nuts and bolts of GP training are difficult to pick up, and I think the theory is harder to pick up...because it's not your everyday. [Senior GP Education Lead]*

For this interviewee, classroom-based learning was necessary for introducing participants to theoretical concepts that they may not otherwise encounter in the course of their work as trainers. This was not to say that learning from practice is automatic or guaranteed - this respondent pointed out that workplace-learning still requires support, but that it can be provided in other ways – such as the local workshops: “when you’ve got a trainee...you have peers to call on, and...going into the network of workshops. So there are opportunities to pick up the nuts and bolts” [Senior GP Education Lead].

However, educational theory should be relevant and learned through “reflecting on it, experiencing it, discussing it with others, relating it to my practice” [Associate Director]. There was a strong sense that theory should be relevant to everyday practice and not taught for the sake of it; “going OTT” [Associate Director], and not necessarily taught in the form of a PGCERT. Theory could be learnt, therefore, by self-study and reflection rather than through lecture-based activities. This way, if you want to learn more you can always do that - an idea picked up by a course participant - but more time on the course could be spent exploring these principles in the context of explicitly explaining how they translate into practice. Other stakeholders felt that demonstrating the applicability of theory to practice through coursework, through essays, was “incredibly helpful in embedding that theory” [Senior GP Education Lead].

Educational theory was considered useful for a variety of reasons. Educational theory raised awareness about the range of ways that learners may vary, about how GP trainers can identify how their registrars learn and therefore support these differences by adapting their teaching and learning approaches. Concerns were raised that without exposure to theory trainers may assume that everybody learns same way as them. One stakeholder provided an example of a trainee being resistant to receiving feedback and that how both theory and experience work flexibly together to achieve a means by which feedback is accepted and acted on:

*And if trainees find receiving feedback difficult you have to have different ways around giving feedback. You have to be flexible. And sometimes it just comes from experience and time and some comes from understanding theory and you know it’s a real mixture. But I think also if we’re going to make this an academic course you need a little bit of academics. [Associate Director]*

For most stakeholders, theory is felt to provide GP trainers with a better understanding of how they could achieve positive outcomes from their trainee (and their interactions with them). One stakeholder felt that the in-depth theoretical knowledge learnt - “deep level thinking” [Senior GP Education Lead] - was important; particularly when dealing with trainees in difficulty. Comparing the new course with the old, one stakeholder [Senior GP Education Lead] felt that courses involving more theoretical knowledge facilitated the development of broader skills and supported in-depth thinking around the challenges of being a trainer. However, not all interviewees agreed – indeed, the role that educational theory plays in ensuring that GP trainers are effective was a contentious issue that is discussed in more detail later in this report.

#### 4.2.3.1 Practical

The introduction to teaching in primary care course (ITTPC), in many instances a prerequisite for the TTT course, gave first-hand experience of teaching. Therefore, in the past those doing the PGCERT may have had some practical experience of teaching and learning prior to coming on course. Being directly

involved in teaching and supervision was important because it made the theory relevant and come alive, this teaching experience could be at undergraduate or postgraduate level:

*There are people who are in the group who didn't, who were not doing any kind of undergraduate or postgraduate teaching. And lots of them, you could hear when we were in our small groups, were kind of frustrated with talking about that. They said they were really looking for much more objective conversation. [Course Participant]*

Being actively engaged with teaching also developed participant's confidence and allowed them to develop their own teaching styles. For one stakeholder, experience was far more important than theory:

*I think to be an educator actually.... You've got to be interested in doing it, I think that far outweighs knowing the background theory. I actually think you need to have experience. [Workshop Convener]*

Another stakeholder noted how there are many aspects to being a good educator; that it is about more than knowing some educational theory:

*An educator has many, many hats, assessment, mental, referee, support, pastoral care, encouragement, reflection, and those are very different hats I'm sure that lots of educators are very effective in some of those roles without knowing about quote, unquote theory. [Associate Director]*

Furthermore 'learning from doing' (i.e. learning from colleagues at the practice) was valued more highly by some than doing the postgraduate certificate. Learning from other colleagues in the workplace emphasised the importance of the operational element to being a GP trainer and supporting and assessing the GP trainee in practice.

The practical/operational emphasis on the course was valued by course participants and stakeholders alike - but perhaps less so by more recently qualified GPs who were already familiar with these processes as they had been through the new forms of assessment themselves. Indeed, understanding all of the hoops that GP trainees need to go through was deemed very important for supervisors to know and the course could be enhanced by advising supervisors how best to support trainees getting through the AKT and CSA examination as well as providing an outline for the year with key milestones:

*You felt like they taught you the stuff that you needed to actually do the job, rather than the theory and then suddenly being thrown in the deep end and not knowing how you actually went about the day-to-day bit, being a trainer. I think they did that really well. So I'm pleased to have had that, but also we've got a bit of theory, and I now feel confident to try a bit more theory I suppose. [Course Participant]*

A Senior GP Education Lead noted the lack of "nuts and bolts" on the previous PGCERT and that a follow-up day for that was required on completion of the programme; also that there was an important steer from more senior stakeholders to ensure that the LGPTC should include this "whilst not becoming a purely nuts and bolts course of just the operational enactment of being a trainer".

Another Senior GP Education Lead noted that they thought LGPTC course participants should feel less anxious about the realities of being a GP trainer because these issues had been attended to:

*I think most people, when they come out of this course, when they end it, they would say, and they have said, they feel it was relevant, and they feel it was useful. So I guess I kind of struggle in two worlds. Some of the feedback I had from trainers has been that they feel that they still come out and they don't really fully understand the practical stuff... Like the portfolio in different types of assessments. [Senior GP Education Lead]*

But it seems that this is not translating into the lived experiences of the course participants.

*One of the things that does come out though, which surprises me, is still this feeling that they're not covering the portfolio or the nuts and bolts. But I don't understand why they think that's missing, because this is much more GP training-orientated than postgraduate certificate was. That was much more theoretical, and I assume all of this will be embedded in examples of GP training... We have a network of patch Associate Deans... And I asked them all, in preparation for this interview, what their thoughts were...And there were slight rumblings that they felt that there weren't - The nuts and bolts hadn't been covered in the same way. But I don't really quite understand why. Because this [the course curriculum] seems very good. [Senior GP Education Lead]*

Indeed, as we will come to discuss, participant's confidence in their ability to train often remained an issue.

#### 4.2.4 Assessment

Stakeholders thought that assessment drives learning, however, they were also quick to highlight that assessments can take a variety of forms. For example, the final assessment on the GP trainers' course is being assessed by an associate director at an approval interview which is their "endpoint exam"; a form of assessment thought to be more valid than previous forms of assessment – such as, written assignments. It was noted that formal assessments could act as a barrier to GPs becoming trainers, and course participants were generally negative about more formal assessments - particularly essay writing. Other options were offered to examine whether course participants had understood the basic principles and could utilise them in practice. Ideas included role plays with real trainees; presentations; the reflective portfolio; and some emphasised the need for *feedback* rather than a typical assessment.

The lack of assessment or monitoring of learning is worrisome for some stakeholders, as it is felt that there is no way of 'checking in' on learners and this could lead to a slip in standards:

*I'm not sure how the self-directed learning days are monitored...or evaluated. I'm not saying assessed but, I mean, how does one know that those days are [used]?... I think that self-directed learning is terrific and they are adult learners, but if one's also responsible - if the purpose of the course is also to ensure that the workforce is of a certain standard, if one's not formally assessing, then there needs to be ongoing - about quality assuring how that's time's used I think... Something about more than just we trust you, you're adults, go and read some journals kind of thing. I think something about engagement during that time perhaps. [Associate Director]*

*I guess the assessment is really the training application, but the question is, does that assure quality? And I don't think, it probably doesn't. And part of that I think is because we're so desperate for trainers that are we going to turn everybody down who's interested? [Senior GP Education Lead]*

*So in the current context, I get it. We need more trainers and we have no money. But I think we still have to think about quality and the bar, and how we're assessing people, you know, but there is no assessment. [Senior GP Education Lead]*

A concern that seems to have some merit:

*I think it's almost a little bit too undemanding of us... In that, you know, we're given a pre-course reading, which you can or cannot do. You turn up. You can or cannot participate. You may or may not have absorbed anything. You may or may not have learnt anything. Everyone is different learners and, I mean ...It can be that some people absorbed loads and have really changed. There will be some people that have literally just turned up, got the stamp and then, you then there'd be no, kind of, like, testing or assessment. I know that's what you're trying to move away from but, like, it hasn't - For me, it's felt, like, great, this has been an easy option. It's been one of the easiest qualifications I've ever acquired. [Course Participant]*

This lack of assessment, along with the short length of the course (which, it is noted by course tutors, can be poorly attended) creates a sense of uncertainty about the effectiveness of course as it's not easy to identify those struggling:

*One of my concerns is - I mean, as you saw this afternoon, several people went early, we'd got two people away, and given this is their only course that they're doing and it's five days, I would have thought attendance and completing a portfolio would be mandatory, rather than making it optional... you know, maybe some people need a bit more help to become a trainer than others and they might need some extra support or - it feels a bit superficial at times. [Course Tutor]*

There is also the worry that that trainers will not be equipped with the necessary skills to manage the complex situations that they are likely to encounter with a new trainee, as there is not enough time to facilitate their development:

*One of the things, I think, the time pressure of it makes me think that so much of what's covered, it seems to be relatively superficial. And so whilst I think their content is useful, and it does cover areas which are really important, my sense has been that the actual skills element and the interpretation, the making sense of some of these concepts, it gives very little time to that... [for HEE there] is the expectation at some point higher up, is to say that, well, that may be something that trainers have to learn on the job for their trainee workshops. So groups - But the reality is that does not happen, and the workshops are not really - I think it needs to be embedded very early on. [Senior GP Education Lead]*

This new course creates a mixed market of trainers; some who have dedicated a year to obtain an accredited PGCERT and some who have attended a five-day, unaccredited course. It is thought that this inevitably leads to tension and rivalry between the two groups, as well as a sense of one course being *better than* the other; therefore, one group being *better than* the other. This was present in the views of both stakeholders and participants:

*It's like almost it used to be an achievement to be a trainer and I think they [participants on older trainer pathway] also feel it's eroding the level of achievement of them being a trainer themselves because now it's become easier to be a trainer. [Senior GP Education Lead]*

*I think that adding in an assessment to something this condensed, what do you assess? [...] Are you making the assessment more about the educational theory side of things? In which case I probably wouldn't have done the course? I would have done a PG Cert and got a higher-level qualification.[...] I think there's a clear distinction between this and a PG Cert. If you start putting assessment into this what's the difference between the two? Why not just do the other one? [Course Participant]*

Indeed, not only does this inevitably lead a sense of one course being *better than* the other, but it also permits the valorisation of the alumnus themselves; a sense that one group of alumni is better than the other (or certainly more 'academic'). There was lots of discussion that differentiated the two alumni; discussion that was *in part* prompted, but which interviewees expanded upon voluntarily. As the following example from one interviewee shows:

*I can see from the people I'm training, actually, that they are a different breed from, perhaps, what they were ten, 15 years ago. They're slightly different in the way they think about things. [...] And I can see, therefore, why this new TTT course might be the way people want. But is what people want these days - rather than the more - sort of, navel-gazing philosophy of immersing yourself in something 100%. [Workshop Convener]*

An additional, perhaps unexpected, value of accreditation that comes from assessment (and outcome of the lack of assessment on the LGPTC) is that it gives those actually doing the training confidence in their abilities. LGPTC participants really struggled with the lack of assessment on the course – as two focus group participants summarised:

*Sometimes we would like to know that we've achieved something so we have some formative assessment at the end of it to say actually, yes, you reached the required standard and now you can go forward. And sometimes that can act as some form of - Get some confidence from that essentially to say, actually, yes, I'm of a certain level whereas at the moment it's uncertain really, where we are. [Course Participant]*

*I don't like assessment but I think, I mean, we've completed this without literally—you don't know if I've learnt anything. And I really might not have done. [Course Participant]*

The relationship between assessment and confidence is clearly underpinned by a 'rubber stamping' process; that passing an assessment provides confidence as it tells the participant that they meet the standards and know all that they need to know to effectively train trainees. There is some suggestion that it is also underpinned by assessment offering the opportunity to provide feedback to the trainers (either positive or constructive); that this offers participants some sort of "benchmark" to measure themselves against so that they know where they stand, and how they can improve.

#### 4.2.4 Fitness for purpose and broader philosophical stance

There was an overwhelming sense that the course was fit for purpose; that, *in theory*, it was sufficiently preparing participants to train trainees. Stakeholders generally felt that the **new GP trainers were prepared for their role**. Some even felt that they may be more prepared than their predecessors in some respects:

*She [LGPTC participant] was more aware of the trainee in difficulty process. And she was more aware of the portfolio [than TTT]. [Associate Director]*

Although most interviewees asked to evaluate their preparedness could only speak in the hypothetical sense and it was too soon in the trainer pathway to have any evidence to speak to this (such as trainee feedback; confirmed numbers of newly accredited trainers). Those stakeholders who had engaged with participants in a meaningful way, expressed some concern that the course might be **too short to prepare new trainers adequately for the role:**

*Comparing it to my own experience of being trained to be a trainer, obviously I thought it [PGCERT] was a better course. I think it [the new course] feels a bit too short and a bit too rushed. [Course Tutor]*

This view was developed by stakeholders drawing on their personal experiences and beliefs about learning -rather than any substantial evidence that this was a problem with the LGPTC – but one course participant voiced similar views. For them, they had very little recent experience of training to draw upon, and to be adequately updated within the timeframe of the new course was clearly challenging:

*I mean, it's because it's been quite a few years since I did the training myself so it's not like it's super familiar to me and I can remember everything [...] At times it hasn't felt very concise and I feel like it's a very short space of time we've got to get what seems to be, like, a lot of stuff in. [Course Participant]*

Indeed, participant's confidence in their ability to train after completing the course remained an issue:

*I don't think that I feel super-confident based on just this course to then go ahead and be a trainer. [Course Participant]*

*So, I still feel anxious about what it's actually going to be like, being a trainer and what I know is, kind of, the overall gist of what they have to do. [Course Participant]*

This lack of confidence is important to note as it may impact on participants preparedness to train. It is also important to reiterate discussions earlier in this chapter and note that not all participants felt unprepared by the course; one LGPTC alumni, who had already been assigned a trainee and had begun training them, felt that they were adequately prepared.

At a far more macro level, there was a philosophical question emerging relating to precisely what the purpose of the course was. As was noted earlier, stakeholders felt that classroom-based learning was necessary for introducing participants to theoretical concepts that they may not otherwise encounter in the course of their work as trainers; implying that stakeholders feel it is necessary for trainers to know theoretical concepts and placing them in direct contrast with most course participants who sometimes did not understand the relevance of it:

*The facilitators, you could see, were really keen to - They're obviously keen educators and experienced educators, and it was clear to see their enthusiasm[for the theory]. But I thought that's fine for someone like me, but I can see in my group there are people here that are thinking, I don't really necessarily care. If I'm being honest, there are people in the group who are thinking, how much money is this as a trainer? What do I need to really tell my trainee to get on board with doing...? Why am I not being told that by month three they should really be doing their AKT, by this month they should do their CSA? When should they go from 30 minutes*

*to 20 minutes to 10 minutes? [Course Participant]*

Indeed, there is a further tension within the data surrounding this point. Most interviewees found it acceptable that trainers know educational theory. Some also felt that it would be advantageous (but not essential) in order for them to train that you can be a 'good' trainer without being a theoretically informed one but being a theoretically informed one might be helpful when training – particularly when faced with an unusual or difficult situation. As one Course Tutor notes, "there are a lot of very good trainers out there that haven't had that kind of educational base [theoretical], and I don't think it makes them a worse trainer, if I'm honest". However, most were also unable to explain why they thought this to be the case, they simply *did*. The discussion below is typical of one had with interviewees:

*I suppose there's all sorts of things to say. I - having been through a Masters of Medical Education and learnt a lot more about theory I feel like I am a better educator. Before, I knew nothing about theory - was it - is it possible to be a good educator [without knowing educational theory]? Yes. It's one thing that knowing about theory makes you a better educator – absolutely, yes - I think theory and experience and reflection definitely do. [Associate Director]*

Indeed, all were asked whether it was possible to be a good trainer or educator without knowing theory and most participants struggled with this. There was a sense that participants felt they *should* say that knowing theory makes you better (especially those that had been exposed to, and engaged with, it); but all pulled on their real experience of either training or trainers (or both) and quickly backed away from that position, concluding instead that whilst theory might be beneficial, it was not necessary. This tension contributes further to the philosophical discussion of the purpose of the course - is it to expose GPs to educational theories? And if so, *why*? What benefit will doing so have?

A further (and arguably related) tension was emerging within interviewees' perceptions of the purpose of the course. That being whether it was to provide a quick but *temporary* solution to an immediate problem of training capacity in London, or to establish an innovative and *permanent* approach to training trainers. That is to say, whether the intended *outcome* was to simply inject high numbers of accredited GP 'trainers' into the London area quickly, or to troubleshoot a new (cost and time efficient) format for producing GP 'educators'. Implicit in this, is a tension over what a 'good trainer' is understood to be. We identified two distinct conceptualisations of a 'good trainer' found implicit within the data: an 'educator' and a 'trainer'. An educator is the label we (and some participants) assigned to a professional who has experience and knowledge of educational theory which they subsequently draw upon when training, resulting in them 'training' in a very reflexive and adaptable way. A 'trainer' is the label we (and some participants) assigned to a professional who is more practically focused and informed, who draws upon their practical experience to help a trainee navigate the complex education pathway in a very literal manner. Course participants fell very much into the latter camp:

*It depends what kind of GP trainer you want. Some people in the group definitely found the whole conversation about that [theory] really frustrating. They said they're here to become GP trainers and tick boxes and to just you know, get on the course to be able to know what they need to know on a really practical objective approach. [Course Participant]*

Only a few, very engaged, participants felt differently to this. Stakeholders who had ‘on the ground’ experience of the training role also fell predominantly into the latter group as well:

*Well I mean we all have sort of discussion amongst the ADs about you know what was good and what was bad really about the [...] original one [trainer pathway], what was lacking. And because they had, it was very, it was multi-disciplinary and they missed out all the practical stuff that [trainers] really needed like how to do an educational supervision, how to, what the portfolio was actually about, how to navigate your way around it. [Associate Director]*

Whilst those in more senior positions tended to hold the view that a good GP trainer could only be an ‘educator’:

*We [stakeholders] were really keen that this didn’t become what we call a nuts and bolts course of just the operational enactment of being a trainer[...] We were very keen that some of the deeper skills about being an educator were included in it [LGPTC]. [...] I think you’re much more likely to be a better educator if you’ve got a thorough understanding of educational theory. You know, I think it’s something that assists you in that developmental journey. [Senior GP Education Lead]*

These philosophical discussions also play into, and impact on, broader discussions about the applicability of this approach to training in a multi-professional context, and whether this is a realistic possibility for the future of training in primary care - as the following discussion with a stakeholder demonstrates:

*Senior GP Education Lead: There’s the whole multi-professional thing, which is a bigger discussion. Are we wanting to train educators or multi-professional training, or just GP trainers, GP training? And I think that is a question that needs to be addressed. What is it we’re trying to do here? Or how does it fit into the bigger picture?*

*Interviewer: What do you think it should be?*

*Senior GP Education Lead: I think we should be training educators [...] if people want to just be GP trainers, they get an additional day or two to look at the nuts-and-bolts of GP training [...] assessments, feedback, all the kind of stuff we need to learn. And then if you want to be a nurse trainer, you go and do your one or two days [on that], if that’s all you want to do [...] And that means that you can start off as GP trainer, and then maybe go into a one-day pharmacy trainer course, further down the line, and that really sets everyone up with the same grounding.*

## 5. Discussion and implications

### 5.1 Summary of main findings

1. What are the perceived strengths and weaknesses of the course?

- Strengths –the increased accessibility of the course, through a more realistic course duration facilitating GPs attendance and its practical focus were a real strength of the course. It was tailored and provided relevant theory which was explored on the face-to-face days. Small group work was also a key strength, tailored for participants learning needs and practice.
- Weaknesses - lack of formative assessment i.e. feedback on participants progress, lack of summative assessment and therefore formal accreditation, lack of content on GP registrar assessments (AKT and CSA). A lack of ongoing support from the LGPTC network was noted and maybe compounded by the limited impact of attendance of the GP Trainer workshops.

2. To what extent does this course effectively prepare GPs to work as Educational Supervisors in primary care?

On balance both stakeholders and participants feel that this course prepares them to work as educational supervisors in primary care: becoming GP trainers. There are some caveats to that and the lack of actual teaching experience being problematic arguably resulting in some participants not feeling confident. For some stakeholders the lack of theory may be problematic and undermine the effectiveness of new GP trainers particularly when they were dealing with unfamiliar or challenging situations, for example trainees in difficulty.

3. To what extent did the online and pre-course elements prepare participants for learning on the course days?

They were important and appeared to be relevant. The fact that they were discussed in the face-to-face days made them particularly useful. The “dry” and more academic texts appeared more challenging to engage with pre-course because they were sometimes difficult to understand and their real-world applicability was sometimes questioned. Some pre-course reading appeared to be off-putting - making participants less likely to explore the postgraduate certificate option.

4. What aspects of the course could be further developed to improve its design, delivery and overall effectiveness?

- Actual teaching experience would help GP trainers understand the role of theory and its applicability to real-world training situations. It may give them more confidence and may increase their feelings of preparedness practice. If actual experience is challenging to organise then proxy experience, through role-play in the small groups may partly replace this gap. Local trainers’ workshops and local networks could also be used to facilitate actual teaching experience but as participants noted a safe learning environment and trust was needed to be able to engage with simulated learning opportunities in a developmental manner.
- Developing assessments appropriate to becoming a GP trainer, which would provide GP trainers with more feedback about their progress on the course. Some form of summative assessment may make them feel that they have “passed” and may provide more validity for external creditors.

- Teaching assessments -the course appeared to provide less information regarding the summative exams that GP registrars take. New GP trainers, understanding their future GP registrars anxiety around these high-stakes assessments, requested more information/instruction to support their learners better
- Ongoing support after the course is finished.

5. Does the course curricular alignment support the development of key transferable skills?

The course supports the delivery of the key transferable skills outlined. However, consideration should be made as to whether these should be adapted in any way to better reflect those key skills felt to be important by stakeholders.

## 5.2 Discussion

As was noted earlier in this report, a number of 'programme theories' informed fieldwork and were tested during our analysis. Each of these will now be discussed, along with any additional points that the data revealed.

### **Programme theory 1: Exposing course participants to educational theory will provide them with a 'toolkit' to use in practice**

Determining the accuracy of this programme theory is complex. Whilst facilitating a meaningful engagement with educational theory is a challenge unto itself, if managed, our data showed that doing so did have some lasting transformative effects; that knowledge of educational theory did enhance the training that trainers were able to provide as they were better prepared to supervise their trainee once assigned. And so it should be noted that, for those who did engage with educational theory, this was very much the case. However, it should also be noted that most course participants that we spoke with did not engage with it. This was because theory in isolation was found to be un-engaging. It is more positively received by course participants when its' contextual relevance was demonstrable. Therefore, a focus on generic educational theory will be problematic if there is a desire to provide trainers with a theoretical 'toolkit'. Furthermore, perceptions of there being 'too much' theory on a course deter participants from subscribing to it, and therefore becoming trainers.

### **Programme theory 2: A course with a more practical focus will attract more course participants**

The data demonstrated that, whilst there are no concrete measures of this theory, it is felt to be very much true. That is to say that the new course appears to have begun to address capacity issues by increasing the accessibility of the GP trainer course. However, there is no current evidence of the conversion rate from course completion to actively training, with personal and systemic factors being implicated in the reasons for this. One suggestion was that GPs coming forward for training demonstrate that they have the support of their practice to do so, given the importance of having the training environment approved as well as the trainer. It would also allow practices to declare that they already had sufficient trainer capacity, if this were the case. There were fears that capacity could be created in the wrong locations i.e. those that were already popular with trainees and well provided-for in terms of trainers. Not only would this not address workforce issues in certain locations, but it was believed to impact negatively on already well-served locations – in areas where trainer capacity exceeds trainee numbers, established trainers may not receive trainees due to perceived pressure to ensure that newly-qualified trainers receive trainees. Targeted recruitment may help to address these issues. The increased demand for the course appears to have precipitated questions of equitability, with tensions arising between the expectations of individuals to be trained as trainers, versus the need

to ensure the provision of trainers across the region. The first-come-first-served approach appears to favour individuals who are motivated to train as trainers (and is perceived to be fair by them), but this may not be a viable strategic approach in terms of workforce planning.

**Programme theory 3: A 'light touch' course with less formal assessment is more appealing to busy clinicians and also reduces barriers and improves access to the trainer pathway**

This programme theory was very strongly supported in the data. However, there were calls from stakeholders for the provision of a more academic – or 'heavy touch' – course, possibly in the form of a PGCERT, amid concerns that a less academic route to trainer approval might leave some trainers unprepared for the more challenging aspects of their role, or for more demanding educational roles in the future (such as PD or AD). The introduction of a formal assessment element within the course was felt by some to be relevant and necessary, even though it was acknowledged that it may put some GPs off attending the course. It may serve a gatekeeping function in the case of 'putting off' doctors who are not suited to the trainer role or suitably motivated to work to become trainers. It may also provide a mechanism for ensuring that self-directed components of the programme.

There is a philosophical divide between the stakeholders planning and designing the course, and those attending and experiencing it – particularly in the case of the perceived usefulness of the local trainer workshops, but also with regards to what is perceived to be needed in order to maximise GP training, and what a 'good' GP trainer is. We noted how the two ideas of a 'good' trainer in the data ('educator' vs 'trainer') are related to ideals about the importance of theoretical and/or practical knowledge in ensuring effective training. We also noted a valorisation of these two kinds of knowledge and the subsequent individuals thought to possess them. Irrespective of the positive or negative ways in which these two groups are discussed, there is a divide being constructed between theory vs practical skills, and so 'educator' vs 'trainer' - which may go on to become problematic in the future as a process of 'othering' takes place on either side of the divide, and is something that course organisers, participants and stakeholders should all be mindful of when discussing these topics and cohorts.

**Programme theory 4: Assessment is not needed to drive learning**

Data suggests this is not believed to be true. The lack of assessment is creating much anxiety for stakeholders and course participants alike; with both groups unsure of course participants' abilities to train upon completion of the course. As was noted, there is a clear relationship between assessment of course participants and confidence in their ability to effectively train. The introduction of *some form* of assessment to the course was felt to be relevant and necessary, even though it was acknowledged that it may put some GPs off attending the course. However, the true value of the assessment (along with the 'rubber stamping') is the opportunity it provides to provide constructive feedback and course participants suggested that they would value some sort of assessment of their progress in order to gauge their performance and build confidence. Again, an additional benefit to incorporating some form of feedback is that it may serve a gatekeeping function in the case of highlighting doctors who are not suited to the trainer role or suitably motivated to work to become trainers. It may also provide a mechanism for ensuring that self-directed components of the programme have been completed. There was no consensus on how assessment should be undertaken, although assessment of skills may be preferable to essay-based theoretical assignments. Assessment for both participants as well as approvers may give greater confidence.

As noted in the previous chapter, a lack of confidence despite exposure to theory highlights the importance of real-world opportunities to teach, including simulated settings.

## **Programme theory 5: Creating local networks of trainers will motivate and support GPs to become trainers**

This programme theory was not supported in the data. There was no evidence that the networks created were encouraging more GPs to become trainers, despite course participants saying they have recommended courses to others. That is not to say that this has not happened – and a number of stakeholders noted that they felt numbers had increased.

Indeed, the local networks of trainers created by this new pathway were much more valuable to impending/newly accredited (rather than potential) trainers. It was recognised that the training for new trainers is currently heavily front-loaded, with trainers only really beginning to apply their learning once they have been assigned a trainee of their own. This was recognised to be a challenging time for newly accredited trainers, and there was backing for the idea of ongoing support, post-course, both through the local trainer workshops and a possible follow-up classroom-based session. It seemed that course participants had informally made connections with their small group discussion colleagues and were provided support to each other. Perhaps more could be made of this opportunity to receive ongoing support in collaboration with HEE LaSE.

### **5.3 Implications**

Implications are best understood in the context of the research questions that we were commissioned to answer:

1. What are the perceived **strengths and weaknesses** of the course?
2. To what extent does this course **effectively prepare** GPs to work as Educational Supervisors in primary care?
3. To what extent did the **online and pre-course elements** prepare participants for learning on the course days?
4. What aspects of the course could be further developed to **improve** its design, delivery and overall effectiveness?
5. Does the **course curricular** alignment support the development of key transferable skills?

#### **5.3.1 What are the perceived strengths and weaknesses of the course?**

The facilitators of the morning sessions and course tutors in the afternoon are clear strengths of the course. LGPTC staff successfully created a good learning environment, where participants felt able to ask questions and contribute. Working in the same small group for the duration of the course was found to be useful by most participants. The continuity allowed for trust to develop, creating a safe space to try out new techniques and receive constructive feedback from peers; this led to increased confidence. This only did not work so well when members of the group did not seem to be particularly engaged in the course in general. **Where possible, future courses should recreate this ‘safe space’ and facilitate the formation of close relationships between engaged peers.**

Furthermore, the opportunity to gain practical knowledge and practice training techniques in the afternoon sessions was perceived as valuable by both course tutors and participants alike. It was felt that addressing the practical elements of the training on the face to face days was very beneficial, and it would work even better if ways could be found for participants to engage with the practical materials further in these sessions. Indeed, course participants will gain more from the LGPTC if they have an opportunity to be practically engaged with teaching or educational activities. This could be pre-course

or during the course, and could possibly be at undergraduate or postgraduate level but may give participants the opportunity to relate educational theory to practice. It may also help develop and build confidence. **Where possible, future courses should incorporate a greater practical focus - for example, giving access to 'dummy' portfolios to practice with.**

The 'light touch' approach to the course content, structure and format, as well as the lack of any formal assessment, has improved access to the trainer pathway to individuals previously marginalised by the demands of the PGCERT. The lack of formal assessment especially (particularly time consuming, heavily theoretical, essay based formal assessment) has made this possible. **Course organisers should consider that formal university accreditation depends on university regulations. However most include some form of written assignment rather than a practically orientated/discursive assessment. Future developments of the course need to bear this element in mind as this may strongly influence the content of the programme.**

Whilst participants understood the benefit of reflecting, some found the formality of writing reflections for a portfolio unhelpful and off-putting, and thus were less likely to engage with the reflective portfolio and so removing themselves from the possibility of being funded to complete the PGCERT – receipt funding being a key factor in some individuals' ability to enrol. There was also some confusion about the purpose of the reflective portfolio and how to do it; this was possibly exacerbated by the fact that doctors have to regularly complete written reflections in other formats for other part of their roles. **Course organisers could consider the purpose and format of the reflective portfolio in more detail. They could also consider making this a compulsory part of the course; one that is reviewed in some way. Portfolios could play an important role in any ongoing formal accreditation or assessment of future programmes.**

The course content that seems to be most important to participants was how to do *really* practical tasks such as helping trainers to complete the portfolio and assessments and supporting them supporting the trainees with the CSA and AKT exams. These day-to-day practical elements seem to be missing on the course and are noted as absent. Perhaps with an assumption that this information will be supplemented by the regional workshops or peer networks – an assumption that is not always true, and does nothing to help with newly accredited trainer anxieties. **Course organisers should consider the restructuring of the curriculum to include a 'dummies guide'/play by play of the 'nitty gritty', day to day tasks.**

### 5.3.2 To what extent does this course effectively prepare GPs to work as Educational Supervisors in primary care?

There is a somewhat abstract discussion emerging within the data with regards to what precisely an effective Educational Supervisor in primary care is. Is it a GP *trainer* – i.e. someone who is familiar with the processes, hoop jumping, and box ticking that a trainee GP has to navigate through; someone so familiar with these that they can offer guidance on how to navigate them alongside ensuring further professional-practical skills are developed by the trainee. Or is it a GP *educator* – i.e. someone who is well-read in terms of educational theory; who employs theoretically informed styles of trainee supervision to inspire learning? The course is very clearly producing the former. Whether or not this means it is effective depends on the views and desires of the organisers – however stakeholders seem to think that this 'trainer' approach (whilst undesirable at an intellectual level) is effectively preparing them, but also that this is an interim, short term solution to dwindling trainer numbers. **Course organisers could consider the philosophy of the course and its alignment to the need in the**

community for ‘trainers’ versus ‘educators’; decisions on (and justifications for) this should also be made more explicit.

### 5.3.3 To what extent did the online and pre-course elements prepare participants for learning on the course days?

The face-to-face days were most beneficial for those participants who prepared for them by engaging with the pre-course materials, and so the online and pre-course elements prepared participants well. However, the challenge for course organisers is to get participants to engage with these elements. Pre-course materials are more popular and likely to be engaged with when participants can see their relevance to their practice. For example, materials such as podcasts and videos were more practically accessible, but also were perceived to be better tailored to the participants’ learning needs. Participants were less engaged with heavily theoretical pre-course elements. **Organisers could consider whether pre-course, theoretical materials (especially lengthy articles) should either be followed up with discussion in face-to-face sessions, or should be issued in digestible volumes and as post-session reading to consolidate the day’s learning.** This is an important element to get ‘right’ in the eyes of course participants, as an implication of getting the balance of theory wrong is that it could negatively influence recruitment if this new course is perceived to be theory focussed.

### 5.3.4 What aspects of the course could be further developed to improve its design, delivery and overall effectiveness?

Both course tutors and participants felt that having more time would be beneficial, as there is a lot of content to cover in five sessions, meaning that there was not as much opportunity for practising practical skills and discussing theoretical concepts as would have been ideal. Furthermore, a course such as the LGPTC is obviously an intervention at a particular moment in time and a number of participants and stakeholders commented on the lack of/need for new trainers to receive support further along the pathway. Whilst this could be largely facilitated by the regional workshops, these meet fairly infrequently and may not catch issues that arise – i.e. at a time when they could be nipped in the bud. **Course organisers should consider the practicalities of an optional ‘follow up’ session that brings new trainers back into the ‘safe space’ of the LGPTC to discuss experiences ‘in the field’.** This would be particularly easy to facilitate and organise as participants seemed to suggest that the small groups that were created as part of the structure of the course (for the purpose of facilitated group discussion activities) remained as a source of support after the end of the course.

Drawing attentions outwards to a more abstract level, we highlighted an emerging tension surrounding whether the intended purpose of the LGPTC was to simply inject high numbers of accredited GP ‘trainers’ into the London area quickly, or to troubleshoot a new (cost and time efficient) format for producing GP ‘educators’; whether the purpose of the course was to provide a *temporary* solution to an immediate problem or to establish an innovative and *permanent* approach to training trainers. The views of stakeholders suggest that the purpose of the course is very much the former of the two; whilst the experience of the course participants suggest that there is scope for it to be the latter. What is crucial in making this decision is first deciding the intended outcome of the course – is it to produce and ‘educator’ or a ‘trainer’? **Course organisers should critically and objectively consider the need for all GP trainers to be exposed to educational theory.**

### 5.3.5 Does the course curricular alignment support the development of key transferable skills?

In terms of the key skills outlined by the organisers (in bold), most stakeholders agreed that the course curriculum gives trainers the necessary ‘toolbox’ to **supervise** effectively. The issue here, however, comes down to course participants possessing the confidence in themselves to realise it. **Adaptability** in supervision is thought by stakeholders and organisers to be enabled by exposure to educational theory, so *in theory* yes, the course does support the development of this key skill. However, ‘adaptability’ developing as a key skill is thus contingent on a real engagement with the course (predominantly the *pre-course materials*) which, as we have shown, not all course participants are doing so. **Communication** – or improvements to it, isn’t emerging as a clear outcome in the data but participants in reflective interviews did comment on how they draw on what they learned on the course when communicating with trainees/others. There are some very concrete – albeit implicit - examples from course participants of having developed **a critical approach to learning**. Interestingly, this demonstration of critical thought is not prompted by an individual-level engagement with theory (i.e. in the pre-course context) but rather through lively discussion on the face to face days – and recollection of them in interviews. Of those who have been engaged with the course, so doing readings etc. the course very much supported the development of **their awareness of educational theory** and this was most noticeable in the reflective interviews. However, the short time frame in which they are exposed to theory, combined with comments from an Associate Director that a LGPTC alumni was the only prospective trainer in a long while who didn’t mention any theory in their assessment interview, raises the question as to how much theory is retained. The answer to this question depends greatly on the interpretation of this point – does “increasing awareness” refer simply to drawing participants attention to the existence of educational theory for them to look up when needed; or is it instilling new knowledge to draw upon in a difficult situation? As this situation appears, for the majority that we spoke to, to be very much former. Data and analysis suggests that the course very strongly develops participant’s **ability to reflect**.

A macro discussion is prompted from our findings, with regards to what key transferable skills *should* be being developed in new trainers. Stakeholders suggested their own key skills that they felt the LGPTC should be developing and, in many ways, these were different from those identified by LGPTC course designers. Approachability, enthusiasm, ability to act as a role model and in a learner-led manner were thought to be key by interviewees and are lacking in the key skills listed above. Notably, awareness of educational theory was lacking from the stakeholder-supplied list. A full list of stakeholder-identified key skills is provided in Table 2.

Table 2: Key transferable skills

Skill	Frequency mentioned
Learner centred	5
<b>Approachable*</b>	2
Adaptable/ flexible	2
Supportive	2
Role model	3
<b>Good communicator*</b>	3

Enthusiastic & positive about profession	3
<b>Reflective*</b>	3
Experienced, professional and 'good' doctors themselves	2
Respectful of patients and colleagues	3

\*also on LGPTC key skills list

## 5.4 Limitations

In this section we report on limitations of our study. Our initial study design included a more balanced representation of participants from both cohorts. Our proposal was to run one focus group with participants from cohort 1 and another with participants from cohort 2 so as to elicit discussion between them and discover similarities and differences in their views on the issues being investigated. Despite repeated attempts to organise the focus group with participants from cohort 1, unfortunately it was not possible to do so, due to a lack of response from this group. As such our results are weighted slightly more heavily towards the views of the second cohort of the LGPTC. Although this slight imbalance is a limitation, again we do not consider it to be seriously limiting to the reliability of our findings, as overall there was significant homogeneity of opinion across stakeholders and participants, and as such we believe that it is unlikely we would have discovered new information of significance even in an ideally balanced sample. Another limitation was that the 'newness' of the course meant that it was challenging to determine the 'real world' effectiveness of it. Stakeholders were able to speak to some outcomes but most had not interacted with LGPTC alumni to any meaningful degree, and were uncomfortable speaking to their perceptions of their skills and abilities.

## 5.5 Concluding remarks

The LGPTC was highly evaluated by participants and stakeholders. The overall feeling was that of a generally well-run course, which was populated by enthusiastic facilitators and course tutors, and which led to significant learning for everyone involved. Fundamental to its success were two key ingredients. Firstly, the learning environment established at the face-to-face taught provided both support and challenge from peers and secondly, the practical focus which allowed participants to engage with, and prepare for, the challenges they are likely to face when supervising a new trainee. Whilst there was some frustration about the theoretical components of the course, and some additional areas for improvement in its format, participants and stakeholders reported the successful development of a number of valuable and transferable skills amongst the two cohorts.

## 6. References

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## 7. Appendices

### *Appendix 1: Interview Schedules*

Please note that these are skeleton interview schedules and were (i) adapted for each interview and (ii) adapted for each stakeholder

#### **Interview Questions A: for course participants**

##### **THE PROGRAMME**

1. To start, we are going to talk about the content of the programme. The programme covers 6 key medical education topics: an introduction to teaching and learning including feedback; curriculum planning; supervision including conversations inviting change; assessment; educational supervision reports including reflection and finally trainees and trainers in difficulty.

- a) What did you think about the content of this programme? Prompts: explore if any of the themes more useful than others and if so why?
- b) Is there anything important missing from the programme?

2. We're now going to discuss each component of the programme in a little more detail:

To start, we are going to explore the **pre-course materials**: am I right in thinking that these included reading materials, some of which were compulsory, videos, and training guides? Anything else?

a) The pre-course materials were provided as a way of supporting self-directed learning. Some would say that self-directed learning is the most efficient way for busy professionals to fit training into their schedules. Would you agree with this? Prompt for why/why not.

b) What did you think about the pre-course materials? Prompt, explore if some were more useful than others and why.

c) Did engaging with these materials inspire you to lookup more information? Prompt: for example, did you look for more to read about educational theory? NB Explore if participants did compulsory readings.

d) Were you able to apply ideas and concepts from the materials you read in the face-to-face/taught days?

e) Some people would say that you can't be a good educator without knowing some theory. What do you think about that?

Moving on to the next component – **the mornings of the face to face training days**- which were intended to explore the educational theory that underpins GP training.

i) Did you find these morning sessions valuable? Prompt: Explore if so why and if not why not. Prompt: explore if they were an opportunity to discuss and understand educational theory?

j) By attending the morning sessions and doing the reading, did you feel you were able to develop a more critical approach to teaching and learning? Prompt: if so why and if not why not.

k) How, if at all, did the peer group discussions enable you to reflect on your approach to teaching and learning?

We would also like you to tell us about the **small group sessions** in the afternoon.

m) In what way, if at all, did the afternoon sessions differ from the morning? Prompt: how able were participants to set the learning agenda? Was there an opportunity for greater discussion? How was that helpful?

n) Small group sessions are believed to compliment didactic teaching by offering students the opportunity to interact with topics & peers under the guidance & facilitation of tutors. It's felt that this creates a tailored and reflexive approach to learning, allowing students to develop detailed subject knowledge and receive ongoing formative assessment of their progress. Has this been your experience of small group sessions? [Unpack responses].

o) The aim of these sessions is to put the theory that you're exposed to in the pre-course reading and morning elements into practice. Do you think this was achieved? How/Why?

p) Overall, did the taught days help you to feel prepared for the next steps of becoming accredited? How/why?

And finally, we'd like to talk to you about the **Reflective portfolio**:

q) Part of this course is the opportunity to complete a reflective portfolio. What are your thoughts about this? Prompt: is everyone intending to complete it explore who is and why and who is not and why.

r) Some would say that reflection on personal practice is critical for healthcare educators. What do you think?

3. I'd now like to ask you some more **general questions** about the programme.

a) Do you think the GP Training Course has covered everything you need to be an effective GP trainer? Prompt: Do you feel ready to train trainees?

b) What impact, if any, has it had on your confidence and preparedness to teach?

c) Has the programme changed the way you teach? How?

d) In education, it's commonly said that assessment drives learning. What do you think about that statement?

e) Some would say that the lack of assessment on this course is problematic. What do you think? PROMPT: some would argue that this means that participants will learn very little, or that there is no way of measuring the courses impact/participants abilities

f) What impact do you think adding a formal assessment to GP Training Course would have? Prompt: would it deter people from becoming GP trainers? Strengths and weaknesses?

g) How do you think the programme could be improved? Why?

h) What are your plans now you've completed the course? Unpack those that are/aren't going into training immediately

i) Would you recommend the programme to others?

4. Is there anything that you wish to add?

### **Interview Questions B: Stakeholders in course delivery - skeleton**

#### **BACKGROUND**

1. Firstly, please could you tell me a little about yourself?
  - a) Name
  - b) Professional background
2. How did you become involved in the GP Training Course and what is your role?
3. Can you tell me about any experience of training or supervision you've had?
  - a) Background
  - b) Training
  - c) Course design?

#### **THE PROGRAMME**

4. To start, we are going to talk about the content of the programme. The programme covers 6 key **medical education topics**: an introduction to teaching and learning including feedback; curriculum planning; supervision including conversations inviting change; assessment; educational supervision reports including reflection and finally trainees and trainers in difficulty.

- a) Reflecting on your experience of [designing/delivering] the course what design or content aspects do you think have been most helpful for participants? Why?
- b) What design or content aspects do you feel have worked less well? Why?

5. We're now going to discuss each of the components **of the programme** in a little more detail:

To start, I'd like to hear what you think about the **pre-course materials**: am I right in thinking that these included reading materials (some of which were compulsory); as well as videos and training guides? Anything else?

- a) It's believed that participants who self-elect onto the GP Training Course will engage with the self-directed learning required of them because they are already motivated to learn. What do you think about this?
- b) In what ways are participants able to apply the ideas and concepts from the materials they read to the face-to-face taught days?
- c) Some people would say that you can't be a good educator without knowing some theory. What do you think about that?

Moving on to the next element – **the taught component**:

- d) It's often thought that self-directed learning needs to be supplemented by regular contact time with tutors. What do you think about this? Prompt: agree/disagree. Why/why not.

- e) Did you feel the participants were able to develop a more critical approach to teaching and learning? Prompt: if so **how & why** and if not, why not.
- f) Do you think the afternoon sessions build on the learning in the morning sessions? Prompt: how & why e.g. were participants able to set the learning agenda? Was there an opportunity for greater discussion? How was that helpful? Are the morning and afternoon sessions similar?
- g) Did peer group discussions in the afternoon sessions enable participants to reflect on approaches to teaching and learning?
- h) The aim of these afternoon sessions is to put the theory learnt from the pre-course reading and morning elements into practice. Do you think this was achieved? How/Why?
- i) Generally, how do you think the **taught days** help participants become prepared for the next steps of becoming accredited? How/why?

And finally, the **Reflective portfolio**:

- j) Some would say that reflection on personal practice is critical for healthcare educators. What do you think?
- k) What value do you think the portfolio brings to the programme?

6. Now I'd like to ask you some more **general questions** about the programme:

- a) In education, it's commonly thought that assessment drives learning. What do you think?
- b) Some would say that the lack of assessment on this course is problematic. What do you think about that? PROMPT: some would argue that this means that participants will learn very little, or that there is no way of measuring the courses impact/participants abilities
- c) What impact do you think adding a formal assessment to GP Training Course would have? PROMPT: Do you think formal assessment should play a greater role on this course? If yes... What format would you suggest? What impact would this have on the number of people that sign up to the course?

## 7. THE COURSE PARTICIPANTS

- a) Have you seen any changes in participants that have taken part on the course? If yes: what?
- b) Have you noticed any change in participant's confidence about teaching and training?

## 8. GP Educator

- a) What are the values & skills of a good GP educator?
- b) What key transferable skills do you think are important for a GP trainer?

9. As you may know, previously, GP trainers had to have **PGCert**, this course replaces that requirement. What are your thoughts? PROMPT: do you think this is a better way of training trainers? How/why?

10. What have been the positive aspects of delivering the GP Training Course?

11. What have been the most challenging aspects of delivering the GP Training Course?

## Interview Questions B: Stakeholders in course outcome - skeleton

### BACKGROUND

1. Firstly, please could you tell me a little about yourself?

- a) Name
- b) Professional background and role in GP training

## THE PROGRAMME

2. To start, we are going to talk about the content of the programme. The programme covers 6 key medical education topics: an introduction to teaching and learning including feedback; curriculum planning; supervision including conversations inviting change; assessment; educational supervision reports including reflection and finally trainees and trainers in difficulty.

- a) What do you think about the content of this programme? Prompts: explore if any of the themes more useful than others and if so why?
- b) Is there anything important missing from the programme? PROMPT: From your experience, are there any topics/areas that seem to be particularly important learning needs for trainees? And do you feel the GP Training Course adequately addresses these needs? If not, how can this be improved?
- c) Some people would say that you can't be a good educator without knowing some educational theory. What do you think about that? PROMPT: is it important to understand the theory behind how people learn, in order to be able to teach? Is professional experience enough qualification to teach?

## THE COURSE PARTICIPANTS

3. It's thought that simultaneously exposing trainees to educational theory, giving them the opportunity to query and discuss complex topics, and providing practical training experience, will lead them to become effective and efficient trainers. Do you agree?

- a) Have you seen any changes in participants approach to GP training by attending this course? If yes, what?
- b) Reflecting on participants going through the course, do you think that the programme influences their practice in any other ways?
- c) Do you think engaging on the programme has helped participants become more confident about being a GP trainer?
- d) Have you seen any changes in their engagement/interaction with at the workshops?
- e) Have course participants approached you with regards to the "next steps" to take on trainees?

4. As you know, the programme was set up to support GPs to become trainers and increase the training capacity in primary care. This new programme, as I am also sure you know, replaces a postgraduate certificate

- a) What are your thoughts on this?
- b) Have you noticed any differences between GP Training Course trainers with those who have done their PGCert?
- c) What do you think are the strengths/weaknesses of the GP Training Course compared to the PGCert? Prompt - balance of theory/practical on the GP Training Course
- d) How do you think the GP Training Course will influence the capacity of GP Trainers in London?  
[unpack]
- e) Do you think it's a model of training which would work for other healthcare professions?  
[unpack]

5. Now I'd like to ask you some more **general questions** about the programme:

- a) In educational theory, it's commonly thought that assessment drives learning. What do you think?
  - b) Some would say that the lack of assessment on this course is problematic. What do you think about that? PROMPT: some would argue that this means that participants will learn very little, or that there is no way of measuring the courses impact/participants abilities
  - c) What impact do you think adding a formal assessment to the GP Training Course would have? PROMPT: Do you think formal assessment should play a greater role on this course? If yes... What format would you suggest?
  - d) How do you feel about the move towards formal accreditation of educators – e.g GMC requirement for more formal training for doctors who want to teach?
  - e) What are the values & skills of a good GP educator?
  - f) What key transferable skills do you think are important for a GP trainer?
6. Some would say that short courses with elements of self-directed learning are the most efficient way for busy professionals to fit training into their schedules. Would you agree with this? Prompt for why/why not.
- a) THE GP Training Course is 10 days long (spread over 5months). It's 50% self-directed learning 50% face-to-face training days and includes an optional reflective portfolio to be completed after the course and in participants' own time. Do you think this design will help to increase the capacity of GP Trainers in London by making it more accessible to potential trainers? [unpack]
  - a) Do you think it's a model of training which would work for other healthcare professions? [unpack]
  - b) Are you aware of any "concrete" outcomes as a result of the change in this way of training GP trainers? Prompt: explore whether they think more people are signing up to the programme, more capacity in GP training et cetera
7. Is there anything that you wish to add, anything we haven't covered or any other reflections?



**UCL Research Ethics Committee**

**Note to Applicants:** It is important for you to include all relevant information about your research in this application form as your ethical approval will be based on this form. Therefore, anything not included will not be part of any ethical approval.

You are advised to read the *Guidance for Applicants* when completing this form.

**Application for Ethical Review: Low Risk**

Are you applying for an urgent accelerated review?      Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
If yes, please state your reasons below. <i>Note: Accelerated reviews are for exceptional circumstances only and need to be justified in detail.</i> Part of the research is to observe training sessions. This research has been commissioned and awarded whilst the program is already running and there are now only two training days left on the course that it will be possible to observe: these are on the 22 <sup>nd</sup> May and 19 <sup>th</sup> June. <b>Our funder has requested that fieldwork start on 22<sup>nd</sup> May.</b> Where possible, we request this to be reviewed at your earliest convenience so that we might meet this tight deadline to begin fieldwork in two weeks.	
Is this application for a continuation of a research project that already has ethical approval? <i>For example, a preliminary/pilot study has been completed and is this an application for a follow-up project?</i>	Yes <input type="checkbox"/>  No <input checked="" type="checkbox"/>
If <b>yes</b> , provide brief details (see guidelines) including the title and ethics id number for the previous study:	

**Section A: Application details**

<b>1</b>	<b>Title of Project</b>	The London General Practitioner Trainer Course: a critical evaluation
<b>2</b>	<b>Proposed data collection start date</b>	<b>22<sup>nd</sup> May 2018</b>
<b>3</b>	<b>Proposed data collection end date</b>	<b>30<sup>th</sup> September 2018</b>

4	<b>Project Ethics Identification Number</b>	13311/001
5	<b>Principal Investigator</b>	Dr Ann Griffin
6	<b>Position held</b> (Staff/Student)	Deputy Director UCL Medical School
7	<b>Faculty/Department</b>	Faculty of Medical Sciences /Research Department of Medical Education
8	<b>Course Title</b> (if student)	
9	<b>Contact Details</b>  Email:  Telephone:	<a href="mailto:a.griffin@ucl.ac.uk">a.griffin@ucl.ac.uk</a>   0207 697 0899
10	<p><b>Provide details of other Co-Investigators/Partners/Collaborators who will work on the project.</b></p> <p><b>Note:</b> This includes those with access to the data such as transcribers.</p>	
	<p><b>Name:</b> Laura Knight/ Paul Crampton/ Michael Page</p> <p><b>Position held:</b> Research Associate/Research Associate/ Senior Lecturer</p> <p><b>Faculty/Department:</b> Faculty of Medical Sciences /Research Department of Medical Education</p> <p><b>Location (UCL/overseas/other UK institution):</b></p> <p><b>Email:</b> <a href="mailto:laura.knight@ucl.ac.uk">laura.knight@ucl.ac.uk</a>/ <a href="mailto:p.crampton@ucl.ac.uk">p.crampton@ucl.ac.uk</a>/ <a href="mailto:m.page@ucl.ac.uk">m.page@ucl.ac.uk</a></p>	<p><b>Name:</b> <b>Transcriber(s) (name unknown)</b></p> <p><b>Position held:</b></p> <p><b>Faculty/Department:</b></p> <p><b>Location (UCL/overseas/other UK institution):</b> <b>UK transcription service – not yet contracted.</b></p> <p><b>Email:</b></p>
	<p>If you <b>do not know</b> the names of all collaborators, please write their roles in the research.</p>	

11	<b>If the project is funded (this includes non-monetary awards such as laboratory facilities)</b>	
	<b>Name of Funder</b>	Health Education England
	<b>Is the funding confirmed?</b>	Yes

<b>12</b>	<b>Name of Sponsor</b>
<p>The Sponsor is the organisation taking responsibility for the project, which will usually be UCL. If the Sponsor is not UCL, please state the name of the sponsor.</p>	

<b>13</b>	<b>If this is a student project</b>
Supervisor Name	
Position held	
Faculty/Department	
Contact details	

<b>Section B: Project details</b>
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The following questions relate to the objectives, methods, methodology and location of the study. Please ensure that you answer each question in lay language.

<b>14</b>	<b>Provide a <i>brief</i> (300 words max) background to the project, including its intended aims.</b>
<p>A new GP Trainer programme has been developed by Health Education England in recognition of the need to expand GP Trainer capacity across London, with a desire to do so equitably and in a manner that supports ongoing professional development for healthcare practitioners: the London General Practitioner Trainer Course (LGPTC). This study aims to develop a holistic understanding of the impact and effectiveness of the LGPTC. The findings are intended to go on to provide the Multi-professional Faculty Development Team at Health Education England greater insight into how best to maximise GP professional development and educational excellence with this specific programme, and also offer valuable insights into broader resources aimed at developing the educational expertise of clinical educators and trainees across health care professions.</p>	

<b>15</b>	<b>Methodology &amp; Methods</b> (tick all that apply)
<input checked="" type="checkbox"/> Interviews* <input checked="" type="checkbox"/> Focus groups* <input type="checkbox"/> Questionnaires (including oral questions)* <input type="checkbox"/> Action Research <input checked="" type="checkbox"/> Observation <input checked="" type="checkbox"/> Documentary analysis (including use of	<input type="checkbox"/> Collection/use of sensor or locational data <input type="checkbox"/> Controlled Trial <input type="checkbox"/> Intervention study (including changing environments) <input type="checkbox"/> Systematic review <input type="checkbox"/> Secondary data analysis – <b>(See Section D)</b>

personal records) <input checked="" type="checkbox"/> Audio/visual recordings (including photographs) <i>*Attach copies to application (see below).</i>	<input type="checkbox"/> Advisory/consultation groups <input type="checkbox"/> Other, give details:
<b>16a</b>	<p><b>Provide – <u>in lay person’s language</u> - an overview of the project;</b> focusing on your methodology and including information on what data/samples will be taken (including a description of the topics/questions to be asked), how data collection will occur and what (if relevant) participants will be asked to do. This should include a justification for the methods chosen. <b>(500 words max)</b></p> <p>Our study is a qualitative research project that involves: conducting (up to) ten, telephone interviews with a range of LGPTC stakeholders; conducting (up to) four focus groups with LGPTC participants; conducting (up to) five one-to-one, unscripted, ‘think out loud’ interviews with LGPTC participants; and conducting (up to) 2 observations of LGPTC training days. This methodological approach is best suited to gathering the high quality, detailed data necessary to effectively and critically evaluate the course. Health Education England has already granted us access to course participants, and we will recruit ‘course stakeholders’ via email.</p> <p>Participants will be asked to discuss their views and experiences about the LGPTC, with a focus on the following themes (please see the attached interview schedules for further details): how, if at all, does this course effectively prepare GPs to work as Educational Supervisors in primary care; what do they perceive to be the strengths and weaknesses of the course; what aspects of the course do they think could be further developed to improve its design, delivery and overall effectiveness; did the online and pre-course elements help to prepare for learning on the course days and with their professional practice; does the course support the development of key, and desired, transferable skills.</p>
<b>16b</b>	<p><b>Attachments</b></p> <p>If applicable, please attach a copy of any interview questions/workshop topic guides/questionnaires/test (such as psychometric), etc and state whether they are in final or draft form.</p> <p>Draft interview and focus group schedules are attached.</p>
<b>17</b>	<p><b>Please state which code of ethics (see Guidelines) will be adhered to for this research (for example, BERA, BPS, etc).</b></p>

This research will adhere to **The Economic and Social Research Council (ESRC)** Framework for Research Ethics.

### Location of Research

**18 Please indicate where this research is taking place.**

UK only (Skip to 'location of fieldwork')

Overseas only

UK & overseas

**19 If the research includes work outside the UK, is ethical approval in the host country (local ethical approval) required? (See Guidelines.)**

Yes  No

**If no**, please explain why local ethical approval is not necessary.

**If yes**, provide details below including whether the ethical approval has been received.

**Note:** Full UCL ethical approval will not be granted until local ethical approval (if required) has been evidenced.

**20 If you (or any members of your research team) are travelling overseas in person are there any concerns based on governmental travel advice ([www.fco.gov.uk](http://www.fco.gov.uk)) for the region of travel?**

Yes  No

**Note:** Check [www.fco.gov.uk](http://www.fco.gov.uk) and submit a travel insurance form to UCL Finance (see application guidelines for more details). This can be accessed here:

[https://www.ucl.ac.uk/finance/secure/fin\\_acc/insurance.htm](https://www.ucl.ac.uk/finance/secure/fin_acc/insurance.htm) (You will need your UCL login details.)

**21 State the location(s) where the research will be conducted and data collected. For example public spaces, schools, private company, using online methods, postal mail or telephone communications.**

Research will be conducted and data may be collected at the following locations: Private company/ies – for example, Health Education England offices and/or other private venues that the teaching takes place in (this is most likely when running focus groups and observations, and may also be a possibility when interviewing stakeholders); and via telephone communications (this is most likely for interviewing stakeholders).

<b>22</b>	<p><b>Does the research location require any additional permissions (e.g. obtaining access to schools, hospitals, private property, non-disclosure agreements, access to biodiversity permits (CBD), etc.)?</b></p> <p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p><b>If yes</b>, please state the permissions required. <i>Please note that the UCL joint research office have advised that HRA approval is not required for this study.</i></p>
<b>23</b>	<p><b>Have the above approvals been obtained?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>If yes</b>, please attach a copy of the approval correspondence.</p> <p><b>If not</b>, confirm they will be obtained prior to data collection. Yes <input type="checkbox"/> No <input type="checkbox"/></p>

### Section C: Details of Participants

In this form ‘participants’ means human participants and their data (including sensor/locational data, observational notes/images, tissue and blood samples, as well as DNA).

<b>24</b>	<p><b>Does the project involve the recruitment of participants?</b></p> <p><b>Yes</b> <input checked="" type="checkbox"/> Complete all parts of this Section.</p> <p><b>No</b> <input type="checkbox"/> Move to Section D.</p>
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<b>Participant Details</b>	
<b>25</b>	<p>Approximate maximum number of participants required: 35</p> <p>Approximate upper age limit: 70 Lower age limit: 18</p> <p>Justification for the age range and sample size:</p> <p>Potential participants for this project are:</p> <ul style="list-style-type: none"> <li>• 10x LGPTC Stakeholders (such as: Heads of Primary Care, Heads (or deputies) of GP schools, LGPTC course leads, LGPTC facilitators, LGPTC programme directors)</li> <li>• 25x LGPTC participants (<i>up to 4 x 5-member focus groups; up to 5 x ‘think aloud’ reflective interviews</i>)</li> </ul> <p>We will purposefully sample LGPTC stakeholders in consultation with the funder. From discussion with them, it is our expectation that there will be 10 LGPTC stakeholders to interview. Stakeholders will vary in relation to their stake in the LGPTC (i.e. by job role).</p>

We will purposefully sample LGPTC participants from both the first and second cohorts. The first cohort will provide the sample for the 'think aloud' interviews, and the second for the 'think aloud' interviews and focus groups. Cohort 1 n= 40(approx.). Cohort 2 n= 40 (approx.).

From previous experience in recruiting doctors and recruiting for focus groups, we anticipate a 50% take up amongst Cohort 2 (so around 20 total participants). It is unknown at this stage how many participants will qualify for the 'think aloud' interviews from the 80 possible – and will remain so until ethical approval is obtained and we are able to approach potential participants and see. For this reason, we have accounted for low numbers meeting the qualification criteria *and* agreeing to take part (5%)

It is our expectation that all participants recruited will vary in relation to their age, gender, and academic & professional background. The age range provided is to capture the age range of those likely to be involved with the LGPTC in some way. As involvement is facilitated via employment (either as a stakeholder or as a participant) the age range provided is the typical working age range.

We feel that 35 is a sufficient number of participants for this study. The nature of qualitative research is that it produces rich, dense, descriptive data that requires detailed and time consuming analysis. Drawing on the research team's expertise, and considering the short time frame to conduct research and analysis in, we feel that 35 is an appropriate number to be able to derive meaningful conclusions from the research.

## Recruitment/Sampling

26 Describe how potential participants will be recruited into the study.

**Observation:** Health Education England will contact all course participants via email to inform them of the research observations and send out participant information sheets and the research teams' contact information, ahead of the observation of training days. Course participants will be given consent forms on training/observation days, and asked to consent to the day being observed.

**Focus Groups:** Course participants will also be asked to be interviewed in the email from Health Education England. Potential participants will be given consent forms on training/observation days, and asked to consent to taking part in the focus groups that will be run over lunch and at the end of the day.

**'Think Aloud' Interviews':** Health Education England will determine who has, and has not, completed an e-portfolio. They will contact those who have done so, to invite them to participant in 'think aloud' interviews with the research team. In this email, possible participants will be invited to the observation days (if not already attending) and will be provided with information sheets and the research teams' contact information.

	<p><b>Stakeholder interviews:</b> Health Education England will compile a list of stakeholders that they would like us to interview. They will introduce us to these individuals via email (after first informing them that they will be doing so, and gaining permission to share their email address with us). We will then approach them to provide detail of the project, along with the participant information sheet and consent forms, and follow up after doing so to see if they consent to take part.</p>
<p><b>Informed Consent</b></p>	
<p><b>27a</b></p>	<p>All possible participants will have been provided with project information sheets in advance of being asked to consent. We will prompt participants to read through the information sheet again and provide them with the opportunity to ask any questions. On the date of data collection, we will hand out consent forms and ask participants to read, ask any questions, sign and return to us.</p> <p>Please see the attached information sheet and consent form for further detail as to what participants are being asked to consent to (such as whether their contribution will be identifiable/anonymous, limits to confidentiality and whether their data can be withdrawn at a later date).</p>
<p><b>27b</b></p>	<p><b>Attachments</b> Please list them below:</p> <ul style="list-style-type: none"> <li>Risk Register</li> <li>Participant information sheet</li> <li>Participant consent form</li> <li>Focus Group Biographical Information Sheet</li> <li>Recruitment emails</li> <li>Qualitative interview and observations schedules (drafts attached)</li> </ul>
<p><b>27c</b></p>	<p>If you are <b>not</b> intending to seek consent from participants, clarify why below:</p>
<p><b>28</b></p>	<p><b>How will the results be disseminated (including communication of results with participants)?</b></p> <p>Results will be provided in a report to Health Education England in the first instance. Important and significant findings will also be published in academic journals, as well as presented at academic conferences. Participants will be given the opportunity to provide their contact information for a copy of the final report to be sent to them.</p>

## Section D: Accessing/Using Pre-collected Data

### Access to data

**29** If you are using data or information held by third party, please explain how you will obtain this. You should confirm that the information has been obtained in accordance with the UK Data Protection Act 1998.

n/a

### Accessing pre-collected data

**30** Does your study involve the use of previously collected data?

**No**  Move to Section E.

**Yes**  Complete all parts of this Section. **Note:** If you ticked any boxes with an asterisk (\*), ensure further details are provided in Section E: Ethical Issues.

**31** Name of dataset/s:

**32** Owner of dataset/s (if applicable):

**33** Is the data in the public domain? Yes  No   
 If not, do you have the owner's permission/license? Yes  No\*

**33** Is the data anonymised? Yes  No   
**If not:**

i. Do you plan to anonymise the data? Yes  No\*   
 ii. Do you plan to use individual level data? Yes\*  No   
 iii. Will you be linking data to individuals? Yes\*  No

**34** Is the data sensitive ([DPA 1998 definition](#))? Yes\*   
 No

**35** Will you be conducting analysis within the remit it was originally collected for? Yes   
 No\*

<b>36</b>	If not, was consent gained from participants for subsequent/future analysis?	Yes <input type="checkbox"/> No* <input type="checkbox"/>
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## Section E: Ethical Issues

### Ethical Issues

<b>37</b>	<p>Please address clearly any ethical issues that may arise in the course of this research and how they will be addressed. Further information and advice can be found in the guidelines.</p> <p>Participants we be recruited by the body that is providing their training, so there is a chance that LGPTC participants will feel obligated to participate, irrespective of whether they actually want to. This will be managed by clearly stating on both the participant information sheet and consent form, and continually emphasising during ‘on the day’ discussions that (i) the research team and research project are separate from Health Education England, and (ii) that participants are not obligated to take part, can withdraw from the research at any time, and can do so without penalty.</p> <p>Some participants may not consent to their behaviour and discussion being observed on the training day, whilst others will. This is challenging as researchers will be observing non-consenting participants at the same time as observing consenting ones. Researchers will be trained to take note of those who do not consent and to only formally record any of the behaviours and comments from those who do consent.</p> <p>Participants will be asked questions related to their work and training. Whilst not designed to be so, there is a chance that participants may be asked to recount events that are particularly distressing for them. To manage this, participants will be frequently reminded that they do not have to discuss any topics that they do not wish to. Researchers will also be trained in how to manage this situation in the unlikely event that participants show signs of distress during data collection including how to spot subtle signs of distress, when to pause/terminate the interview, and how to provide sufficient support whilst maintaining professionalism. Researchers will also be prepared with a list of counselling services to offer distressed participants, these will also be provided to participants afterwards, should the distress arise after the interview/focus group has ended.</p>
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### Risks & Benefits

<b>38</b>	<p>Please state any <i>benefits</i> to participants in taking part in the study (this includes feedback, access to services or incentives),</p> <p>There are no known benefits to participants in taking part in the study.</p>
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39	<p>Do you intend to offer incentives or compensation, including access to free services)?</p> <p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p><b>If yes, specify the amount to be paid and/or service to be offered as well as a justification for this.</b></p>
40	<p>Please state any <i>risks</i> to participants and how these risks will be managed.</p> <p>Participants will disclose personal information and views to researchers. There is a very low risk that this information may be lost or mishandled, resulting in a confidentiality breach. To manage this risk, researchers will be trained on how to manage data confidentially and will strictly follow UCL data management protocols. Data will be anonymised at the earliest possible point and stored securely on UCL systems and will not be retained for longer than is reasonably necessary for the completion of the project. This anonymised data will be held in a different location on UCL systems to the non-anonymised data (which will be stored as an encrypted file – password protected – and deleted as soon as data has been anonymised).</p> <p>There is an additional, though unlikely, risk that data from participants who do not consent to being observed are collected and their behaviour &amp; comments analysed and reported. This will be managed by ensuring that all researchers are fully trained on (i) the significance and importance of obtaining consent; and (ii) how to collect group-observation data when consent has not been given from a member of the group. Furthermore, in the event that one or more members of the group does not consent to their information being collected, we will ensure that all data is ‘cleaned’ post-fieldwork but pre-anonymisation and analysis. This will involve a detailed discussion between the research team, who will go through all field notes and recordings and ensure that all responses and behaviours from non-consenting individuals are removed before analysis begins.</p>
41	<p>Please state any <i>risks</i> to you or your research team and how these risks will be managed.</p> <p>There is a very low risk posed to the safety of researchers conducting one-on-one, face-to-face interviews with course participants. To manage this risk, researchers will be briefed on safety procedures for lone working and allocated a ‘buddy’ who they will update with regards to meeting/interview location time expected to start and finish, and contact to let know they have arrived and left safely.</p>

**Section F: Data Storage & Security**

Please ensure that you answer each question and include all hard and electronic data.

**42 Will the research involve the collection and/or use of personal data?**

Yes  No

**Personal data** is data which relates to a living individual who can be identified from that data OR from the data and other information that is either currently held, or will be held by the data controller (the researcher).

This includes:

- any expression of opinion about the individual and any intentions of the data controller or any other person toward the individual.
- sensor, location or visual data which may reveal information that enables the identification of a face, address, etc (some postcodes cover only one property).
- combinations of data which may reveal identifiable data, such as names, email/postal addresses, date of birth, ethnicity, descriptions of health diagnosis or conditions, computer IP address (if relating to a device with a single user).

If you do not have a registration number from Legal Services, please clarify why not:

**43 Is the research collecting or using**

- sensitive personal data as defined by the UK Data Protection Act (racial or ethnic origin / political opinions / religious beliefs / trade union membership / physical or mental health / sexual life / commission of offences or alleged offences), and/or
- data which might be considered sensitive in some countries, cultures or contexts.

**If yes**, state whether explicit consent will be sought for its use and what data management measures are in place to adequately manage and protect the data.

Not intentionally or explicitly, although there is a chance that participants will disclose this information with us. In the event that this happens, we will ensure that this data is managed and protected adequately by anonymising this information at the earliest possible point and storing it securely on the UCL S drive.

**44 All research projects using personal data must be registered with Legal Services before the data is collected, please provide the Data Protection Registration Number: Z6364106/2018/05/22**

If you do not have a registration number from Legal Services, please clarify why not:

**45 State what types of data will be generated from this project** (i.e. transcripts, videos, photos, audio tapes, field notes, etc).

Non- anonymised field notes and audio recordings; and anonymised transcripts and field notes.

Data will be anonymised after collection where all references made by participants to theirs' or others' names, locations and any other statements that its felt will reveal their identity will be redacted. For example: the statement "My son John Barnes, lives near me in Kent" would be changed to "My son [name], lives near me in [location]".

**How will data be stored, including where and for how long?** This includes all hard copy and electronic data on laptops, share drives, usb/mobile devices.

The data will be stored on the secure UCL S drive:

S:\Medical\_School\UMSC\_MedSchool\_ActiveResearch which is only accessible via password to UCL Medical School research staff. Only members of the Research Department for Medical Education and professional staff involved in this research will be given access to these folders. The shared S: drive is a 'shared data storage facility'. All data is backed up to industry best practice standards (90 days) on two virtual server environments, and should one data centre encounter any issues, the other will seamlessly take over.

Data may also be stored on encrypted USB sticks for a short period after data collection before it can be transferred to the s:drive. These are Advanced Encryption Standard 256 <https://www.istorage-uk.com/product/datashur/> . Although, to minimise the risk of loss or disclosure, a secure remote connection to UCL will be used wherever possible. Where portable computers are used they will be password protected and no data will be stored on the hard drive. Where paper-based document sharing is necessary any identifiable sensitive data will be anonymised and stored in locked drawers and cupboards where only the research team will have access.

**Who will have access to the data, including advisory groups and during transcription?**

The research team at UCL's Research Department for Medical Education, and a (yet to be selected) UK-based transcription service will have access to the audio recordings. We will only use a transcription service registered with the UCL procurement office. **We confirm that our transcribers will be made aware of their responsibilities regarding the new General Data Protection Regulations. Including the responsibility of report any breaches of data to UCL, as UCL must report these within 72 hours.**

The research team at UCL's Research Department for Medical Education will have sole access to field notes from observations and full transcripts once received from the transcription service.

All individuals with access to this data will be required to sign a confidentiality agreement form which includes information on storage and transfer.

**46 Do you confirm that all personal data will be stored and processed in compliance with the Data Protection Act 1998 (DPA 1998).**

Yes  No

If not, please clarify why.

**We will also ensure that we are GDPR compliant.**

**47 Will personal data be processed or be sent outside of the European Economic Area (EEA)?\***

Yes  No

If yes, please confirm that there are adequate levels of protection in compliance with the DPA 1998 and state what the arrangements are below.

**\*Please note** that if you store your research data containing identifiable data on UCL systems or equipment (including by using your UCL email account to transfer data), or otherwise carry out work on your research in the UK, the processing will take place within the EEA and will be captured by Data Protection legislation.

### After the project

**48 What data will be stored and how will you keep it secure?**

All anonymised data will be kept securely after the completion of the project. We will comply with the legislation and the policies of UCL around the transmission, storage and sharing of any sensitive information. Therefore, anonymised transcriptions and field notes will be archived and kept securely for up to ten years on the secure UCL S drive: S:\Medical\_School\UMSC\_MedSchool\_ActiveResearch which is only accessible via password to UCL Medical School research staff.

#### Where will the data be stored and who will have access?

The data will be stored on the secure UCL S drive: S:\Medical\_School\UMSC\_MedSchool\_ActiveResearch which is only accessible via password to UCL Medical School research staff. Only members of the Research Department for Medical Education and professional staff involved in this research will be given access to these folders. The shared S: drive is a 'shared data storage facility'. All data is backed up to industry best practice standards (90 days) on two virtual server environments, and should one data centre encounter any issues, the other will seamlessly take over.

**Will the data be securely deleted?** Yes  No

If yes, please state when this will occur: Within ten years of the project completion.

<b>49</b>	<p><b>Will the data be archived for use by other researchers?</b>    Yes <input type="checkbox"/>                  No <input checked="" type="checkbox"/></p> <p><b>If yes</b>, please provide further details including whether researchers outside the European Economic Area will be given access.</p>

<p><b>Section G: Declaration</b></p> <p><b>I confirm that the information in this form is accurate to the best of my knowledge.</b></p>
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Signature	
Date	8/5/2018

**If student:**

**I have met with and advised the student on the ethical aspects of this project design.**

Supervisor Name:

Supervisor Signature:	
Date:	

<p><b>Signature of Head of Department (or Chair of the Departmental Ethics Committee)</b></p>
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**Part A**

I have read the 'criteria of minimal risk' as defined on page 3 of the Guidelines (<http://ethics.grad.ucl.ac.uk/forms/guidelines.pdf>) and I recommend that this application be considered by the Chair of the UCL REC.

Yes                   No

**Part B**

**I have discussed this project with the principal researcher who is suitably qualified to carry out this research and I approve it. I am satisfied that\*\* (highlight as appropriate):**

**1. Data Protection registration:**

- has been satisfactorily completed

**2. A risk assessment:**

- has been satisfactorily completed

**3. Appropriate insurance arrangements are in place and appropriate sponsorship [funding] has been approved and is in place to complete the study.**

Yes  No

**4. A Disclosure and Barring Service check(s):**

- is not required

**Note:** Links to details of UCL's policies on the above can be found at:  
<http://ethics.grad.ucl.ac.uk/procedures.php>

**\*\*If any of the above checks are not required please clarify why below.**

Name:	Dr Ann Griffin
Signature:	
Date:	8/5/2018

Updated 19.10.2017